OREGON BULLETIN

Supplements the 2016 *Oregon Administrative Rules Compilation*

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For June 16, 2016–July 15, 2016

Published by
JEANNE P. ATKINS
Secretary of State

INFORMATION ABOUT ADMINISTRATIVE RULES

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 Notices of Proposed Rulemaking and Rulemaking Hearing. The Bulletin also includes 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.

OAR Citations

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). For example, Oregon Administrative Rules, chapter 166, division 500, rule 0020 is cited as OAR 166-500-0020.

Understanding an Administrative Rule's "History"

State agencies operate in an environment of ever-changing laws, public concerns and legislative mandates which necessitate ongoing rulemaking. To track changes to individual rules and organize the original rule documents for permanent retention, the Administrative Rules Unit maintains history lines for each rule, located at the end of the rule text. OAR histories contain the rule's statutory authority, statutes implemented and dates of each authorized modification to the rule text. Changes are listed chronologically in abbreviated form, with the most recent change listed last. In the history line "OSA 4-1993, f. & cert. ef. 11-10-93," for example, "OSA" is short for Oregon State Archives; "4-1993" indicates this was 4th administrative rule filing by the Archives in 1993; "f. & cert. ef. 11-10-93" means the rule was filed and certified effective on November 10, 1993.

Locating Current Versions of Administrative Rules

The online version of the OAR Compilation is updated on the first of each month to include all rule actions filed with the Administrative Rules Unit by the 15th of the previous month. The annual printed OAR Compilation volumes contain text for all rules filed through November 15 of the previous year. Administrative Rules created or changed after publication in the print Compilation will appear in a subsequent edition of the online Bulletin. These are listed by rule number in the Bulletin's OAR Revision Cumulative Index, which is updated monthly. The listings specify each rule's effective date, rulemaking action, and the issue of the Bulletin that contains the full text of the adopted or amended rule.

Locating Administrative Rule Publications

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 printed OAR Compilation may be ordered from the Administrative Rules Unit, Archives Division, 800 Summer Street NE, Salem, Oregon 97301, (503) 373-0701.

Filing Adminstrative Rules and Notices

All hearing and rulemaking notices, and permanent and temporary rules, are filed through the Administrative Rules Unit's online filing system. 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 Bulletin and OAR Compilation postings. Filings must contain the date stamp from the deadline day or earlier to be published the following month.

Administratrative Rules Coordinators and Delegation of Signing Authority

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. Agencies that 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 keep the forms updated. The Administrative Rules Unit does not verify agency signatures as part of the rulemaking process.

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.

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.

TABLE OF CONTENTS

EXECUTIVE ORDER NO. 16 - 10

INVOCATION OF EMERGENCY CONFLAGRATION ACT FOR THE WASCO COUNTY TRAIN DERAILMENT IN WASCO COUNTY

Pursuant to my authority as Governor of the State of Oregon, I find that:

The fire known as the "Wasco County Train Derailment" is burning in Wasco County.

The resources necessary for protecting life and property from the rail car fire are beyond local capabilities. Assistance with life, safety, and structural fire protection was requested by Chief Jim Appleton, Mosier Rural Fire District. The State Fire Marshal concurs with that request.

In accordance with ORS 476.510 – ORS 476.610, I have determined that a threat to life, safety, and property exists due to a fire caused from the train derailment in Wasco County and the threat exceeds the firefighting capabilities of local firefighting personnel and equipment. Accordingly, I have invoked the Emergency Conflagration Act.

These findings were made at 9:32 p.m. on June 3, 2016 and I now confirm them with this Executive Order.

NOW THEREFORE, IT IS HEREBY DIRECTED AND ORDERED:

1. The Oregon State Police and the Office of State Fire Marshal shall mobilize fire resources statewide and coordinate with all appropriate Fire Defense Chiefs for the use of personnel and equipment in accordance with the Emergency Conflagration Act to suppress and contain this fire. Resources responding to Wasco County Train Derailment, burning near the town of Mosier may be redistributed by the State Fire Marshal.

2. This emergency is declared only for the town of Mosier threatening structures in Wasco County near the town of Mosier.

3. This order was made by verbal proclamation at 9:32 p.m. the 3rd day of June, 2016 and signed this 19th day of July, 2016, in Salem, Oregon.

/s/ Kate Brown
Kate Brown
GOVERNOR
ATTEST

/s/ Jeanne P. Atkins
Jeanne P. Atkins
SECRETARY OF STATE

EXECUTIVE ORDER NO. 16 - 11

INVOCATION OF EMERGENCY CONFLAGRATION ACT FOR THE AKAWANA FIRE IN JEFFERSON COUNTY

Pursuant to my authority as Governor of the State of Oregon, I find that:

The fire known as the "Akawana Fire" is burning in Jefferson County.

The resources necessary for protecting life and property from the Akawana Fire are beyond local capabilities. Assistance with life, safety, and structural fire protection was requested by Brian Huff, Jefferson County Fire Defense Board Chief. The State Fire Marshal concurs with that request.

In accordance with ORS 476.510 – ORS 476.610, I have determined that a threat to life, safety, and property exists due to a fire known as the Akawana Fire in Jefferson County and the threat exceeds the firefighting capabilities of local firefighting personnel and equipment. Accordingly, I have invoked the Emergency Conflagration Act.

These findings were made at 1:40 p.m. on June 8, 2016 and I now confirm them with this Executive Order.

NOW THEREFORE, IT IS HEREBY DIRECTED AND ORDERED:

1. The Oregon State Police and the Office of State Fire Marshal shall mobilize fire resources statewide and coordinate with all appropriate Fire Defense Chiefs for the use of personnel and equipment in accordance with the Emergency Conflagration Act to suppress and contain this fire. Resources responding to Akawana Fire, burning near the town of Culver may be redistributed by the State Fire Marshal.

2. This emergency is declared only for the Akawana Fire threatening structures in Jefferson County near the town of Culver.

3. This order was made by verbal proclamation at 1:40 p.m. the 8th day of June, 2016 and signed this 14th day of July, 2016, in Salem, Oregon.

/s/ Kate Brown
Kate Brown
GOVERNOR

ATTEST

/s/ Jeanne P. Atkins
Jeanne P. Atkins
SECRETARY OF STATE

EXECUTIVE ORDER NO 16 - 12

ENHANCING GUN SAFETY IN OREGON

In the past 17 months, more than 600 Oregonians have died from gun violence—more than 100 of those deaths were homicides.

This, coupled with several devastating episodes of gun violence in other states, calls for immediate action to protect Oregonians and our communities from gun violence.

Ensuring that existing Oregon laws are enforced to their fullest extent increases the likelihood that illegal firearm deals will be detected and guns kept out of the hands of people legally prohibited from having them ("prohibited persons"). Giving the Oregon State Police and other local authorities the tools to track and analyze gun transactions is an important step in that direction.

NOW, THEREFORE, IT IS HEREBY DIRECTED AND ORDERED:

1. Oregon Revised Statutes 166.412(7) and 166.436(5) make it clear that Oregon State Police (OSP) has authority to retain firearms transactions data for five years, although it currently does not retain the data for that long. I hereby direct OSP to update its software and backup programs and to begin retaining data for as long as the department is statutorily authorized to do so.

a. The department shall use data available from the federal eTRACE program, as well as the department's rolling five year data, to trace all firearms used in the commission of a crime that come into its possession: (1) as collected evidence; or (2) as submitted to the department by another agency for forensic examination.

b. The department shall examine data obtained in paragraph 1(a), above, to determine if purchase patterns exist thus allowing for appropriate investigations to be initiated.

2. Oregon Revised Statutes 166.412(7)(c) provides that OSP can report to local law enforcement agencies when a prohibited person attempts to obtain a firearm and the transaction is denied. When that occurs, either the department or a local agency conducts an investigation into the attempted unlawful acquisition. The department generates a report tracking all denials and the dispositions of any new criminal cases initiated after such an investigation is completed. I am directing the department to continue its current investigation and reporting practices. In addition, regardless of whether the department or another agency investigates the new potentially criminal activity, I am directing the department to share the report of the attempted acquisition with relevant local authorities in the following circumstances:

a. When the prohibited person is on probation, notification shall be made to the supervising judge, the supervising community corrections department, and the District Attorney's Office.

b. When the prohibited person is on parole or post-prison supervision, notification shall be made to the community corrections department or the Board of Parole and Post-prison Supervision.

c. When the prohibited person is subject to a court-issued release agreement or protective order, notification shall be made to the issuing judge and the District Attorney's Office.

d. When the prohibited person is subject to supervision by the Psychiatric Security Review Board (PSRB) or Juvenile PSRB, and a firearms prohibition has resulted from that supervision, notification shall be made to the supervising Board.

3. In order to develop future policies that will enhance firearm safety in Oregon:

a. I direct the Oregon Health Authority (OHA) to determine whether it receives the appropriate data to properly and thoroughly study the effects of gun violence and suicide in Oregon. If there is additional data that would further inform the agency, it shall work with my office to determine whether executive action or statutory amendment is necessary to obtain the data. OHA shall share any data it has available with an institution of higher learning or other entity engaged by the state to study firearms related deaths or crimes. Finally, OHA will report annually on gun violence and its effect on public health and, when warranted, recommend policies to reduce gun violence in Oregon.

b. I am creating a new work group to review and assess gun-related domestic violence offenses in two ways:

i. In counties that have established gun relinquishment protocols in domestic violence cases, review the outcomes and make recommendations as to whether a statewide policy would enhance the safety of domestic violence survivors and Oregonians generally; and

ii. Ensure that when an individual is subject to a court order in a domestic violence case that prohibits the individual from possessing a firearm, the prohibition is transmitted in a timely manner to the systems utilized for criminal history records checks when a concealed handgun license is sought or a firearms transaction is attempted. The work group will make recommendations to improve the effectiveness of the system and close any gaps that are identified.

4. This Executive Order will remain in effect unless and until it is superseded by statute or another Executive Order

Done at Salem, Oregon, this 15th day of July, 2016.

/s/ Kate Brown
Kate Brown
GOVERNOR

ATTEST

/s/ Jeanne P. Atkins
Jeanne P. Atkins
SECRETARY OF STATE

REQUEST FOR COMMENT
PROPOSAL TO SUBMIT 1915(I) STATE PLAN RENEWAL

COMMENTS DUE: 10/7/16
BACKGROUND: Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(i) to the Social Security Act (the Act) providing states the option to offer home and community-based services through the state's Medicaid state plan that had previously been available only through 1915(c) HCBS waiver authority.

The Affordable Care Act expanded coverable services under 1915(i) to include any of the HCBS permitted under section 1915(c) HCBS waivers, certain services for individuals with mental health and substance use disorders, and other services requested by a state and approved by the Secretary of Health and Human Services.
PROPOSAL: OHA has operated a 1915(i) HCBS state plan since 2012 under a 5 year approval period. If approved, this submission will renew the plan for another 5 year period and assure that we are compliant with new federal requirements for home and community based services settings published by the Centers for Medicare and Medicaid Services on January 16, 2014. The services to be provided under Oregon's 1915(i) HCBS renewal are essentially the same as the original plan with services that include Home Based Habilitation, Behavioral Habilitation and Psychosocial Rehabilitation Services. The renewal will be adding a formal quality improvement strategy, and processes for independent assessments, person-centered planning, conflict free case management and person centered service plan development.

The reimbursement methodology has not changed from the prior plan, Procedure codes identified and allowed as (i) plan services are H0046 (Home-based Habilitation), T1020 (Facility-based habilitation), S5141 (adult foster care) and H2018 (Psychosocial Rehabilitation) with an HW modifier. The behavioral health fee schedule is located at: http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx

Additional information on the Oregon Medicaid behavioral health service webpage at: http://www.oregon.gov/oha/healthplan/Pages/behavioralhealth.aspx
EFFECTIVE DATE: 1/1/17
HOW TO COMMENT: Send written comments by fax, mail or email to:

Jesse S. Anderson, State Plan Manager
Oregon Health Authority, Health Policy and Ananlytics
Phone #(503)945-6958
Fax # (503)947-1119
jesse.anderson@state.or.us

NEXT STEPS: OHA will consider all comments received. A 1915(i) state plan renewal application will be submitted to the Centers for Medicare and Medicaid Services.

REQUEST FOR COMMENTS
PROPOSED PROSPECTIVE PURCHASER AGREEMENT FOR CARCO/VARICAST SITE

COMMENTS DUE: 5 p.m., Tuesday, Aug. 30, 2016
PROJECT LOCATION: 866-900 N Columbia Boulevard, Portland, Oregon
PROPOSAL: The Department of Environmental Quality seeks comments on its proposed consent judgment for a prospective purchaser agreement with The Pickle Factory, LLC concerning its acquisition of real property located at 866-900 N Columbia Boulevard, Portland, Oregon.

The CARCO/Varicast site has been in industrial use since the early 1920s including automobile tire manufacturing from the 1920s to 1950 followed by pipe and fitting work, metals casting, and glass recycling operations until recent times.

The site has been in the DEQ cleanup program since 2002. Soil contaminated with coal tar was removed from the site and the stormwater system was cleaned out. The site received a conditional no further action determination from DEQ, but the owner declined to settle with DEQ for potential Columbia Slough sediment contamination.

The site owner is updating the existing site stormwater system prior to property transaction and the Pickle Factory will provide $60,000 in funding to the Columbia Slough Settlement Program. After repair and upgrade of the existing buildings on the site, The Pickle Factory then plans to rent the updated space for craft/industrial use. The Pickle Factory will comply with an Easement and Equitable Servitudes and a Contaminated Media Management Plan as approved by DEQ, for all activities on the site.

DEQ created 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 the 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 judgment will provide The Pickle Factory 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 judgment also will provide The Pickle Factory with third party liability protection.
HOW TO COMMENT: Send comments to DEQ Project Manager Robert Williams at 700 NE Multhomah St., Suite 600, Portland, Oregon 97232 or williams.robert.k@deq.state.or.us. For more information contact the project manager at 503-229-6802.

Find information about requesting a review of DEQ project files at: http://www.deq.state.or.us/records/recordsRequestFAQ.htm

Find the File Review Application form at: http://www.deq.state.or.us/records/RecordsRequestForm.pdf

To access site summary information and other documents in the DEQ Environmental Cleanup Site Information database, go to http://www.deq.state.or.us/lq/ECSI/ecsi.htm, select "Search complete ECSI database", then enter 3389 in the Site ID box and click "Submit" at the bottom of the page. Next, click the link labeled 3389 in the Site ID/Info column. Alternatively, you may go directly to the database website for this page at http://www.deq.state.or.us/lq/ECSI/ecsidetail.asp?seqnbr=3389

Find information about requesting a review of DEQ project files.

Find the file review application form:

If you do not have web access and want to review the project file contact the DEQ project manager.
THE NEXT STEP: DEQ will consider all public comments received by the date and time stated above before making a final decision regarding the proposed consent judgment.
ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. If you need information in another format, please contact DEQ toll free in Oregon at 800-452-4011, email at deqinfo@deq.state.or.us, or 711 for people with hearing impairments.

REQUEST FOR COMMENTS
PROPOSED CERTIFICATE OF COMPLETION FOR HOYT STREET PROPERTIES, LLC

COMMENTS DUE: 5 p.m., Tuesday, Sept. 6, 2016
PROJECT LOCATION: 1075 NW Northrup St. and 1315 NW 11th Ave., Portland
PROPOSAL: DEQ is preparing to certify that all required actions have been satisfactorily completed on two blocks of the former Hoyt Street Railyard.
HIGHLIGHTS: In February 2002 Hoyt Street Properties, LLC entered into a Consent Decree with DEQ and agreed to remediate contaminated soils within the former Hoyt Street Railyard, including identifying and properly disposing of contaminated soils and capping each developed city block with a combination of buildings, pavement and three feet of clean soil.

Contaminated soils were removed from Block 15 of the railyard from July 2014 to March 2015 and a condominium tower was constructed on the block. Contaminated soils were removed from Block 17 of the railyard from February 2014 to June 2015 and an apartment tower was constructed on the block.

DEQ reviewed the requirements of the Consent Decree and the corresponding actions, and has made a preliminary determination that all obligations of the Consent Decree have been satisfactorily performed on Blocks 15 and 17 of the former Hoyt Street Railyard. DEQ proposes to issue a certification of completion for the two blocks.

HOW TO COMMENT: Send comments to DEQ Project Manager Kevin Dana at 700 NE Multnomah Street, Suite 600, Portland, Oregon, 97232 or dana.kevin@deq.state.or.us. For more information contact the project manager at 503-229-5369.

Find information about requesting a review of DEQ project files.

Find the file review application form.

To access site summary information and other documents in the DEQ Environmental Cleanup Site Information database, go to http://www.deq.state.or.us/lq/ECSI/ecsi.htm, select "Search complete ECSI database", then enter either **5894** for Block 15 or **5867** for Block 17 in the Site ID box and click "Submit" at the bottom of the page. Next, click the hyperlinked Site ID number in the Site ID/Info column. Alternatively, you may go directly to the database website for Block 15 at http://www.deq.state.or.us/Webdocs/Forms/Output/FPController.ashx?SourceId=5894&SourceIdType=11 or for Block 17 at http://www.deq.state.or.us/Webdocs/Forms/Output/FPController.ashx?SourceId=5867&SourceIdType=11.

If you do not have web access and want to review the project file contact the DEQ project manager.

THE NEXT STEP: DEQ will consider all public comments received by the date and time stated above before making a final decision regarding the completion certification of the remedial actions taken at the site. A public notice of DEQ's final decision will be issued.

ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. If you need information in another format, please contact DEQ toll free in Oregon at 800-452-4011, email at deqinfo@deq.state.or.us, or 711 for people with hearing impairments.

REQUEST FOR COMMENTS
PROPOSED NO FURTHER ACTION FOR SHERIDAN FCI

COMMENTS DUE: 5 p.m., Wednesday, Aug. 31, 2016

PROJECT LOCATION: 27072 Ballston Rd., Sheridan, Oregon

PROPOSAL: The Sheridan Federal Correction Facility, south of the City of Sheridan in Yamhill County, proposes No Further Action related to the environmental contamination at the prison. Surface spills and leaking underground storage tanks allowed petroleum and other chemicals to enter the environment, contaminating soil and groundwater. The work is being done pursuant to Oregon Administrative Rules Chapter 340 Division 122, Sections 010 to 0140 and Oregon Revised Statute 465.200 through 465.455.

HIGHLIGHTS: The site operates as a federal prison that has had multiple releases during facility operations. A diesel spill from an above-ground storage tank occurred in 2003, creating Environmental Cleanup Site Inventory No. 4083. Emergency response actions included soil removal, pumping diesel-contaminated groundwater from utility trenches and placing absorbent booms in a nearby drainage ditch.

Numerous above-ground and underground storage tanks were used at various locations, including a warehouse and factory. Petroleum was detected in soil around the tanks following removal in 2006, initiating LUST 36-06-0382. However, water containing methyl-ethyl ketone was pumped from excavation at the factory tank. As part of cleanup actions, 10.86 tons of soil were removed from this location and disposed of at a landfill.

Methyl-ethyl ketone and other contaminants were detected in water from an on-site irrigation well first reported to DEQ in 2010. The well water was sampled several times, with the most recent tests indicating no methyl-ethyl ketone detections. Water from two private wells north of the prison were tested but did not contain any contaminants related to the site.

HOW TO COMMENT: Send comments to DEQ Project Manager Cathy Rodda at 165 E. 7th Ave., Ste. 100, Eugene, OR 97401 or email rodda.cathy@deq.state.or.us. For more information contact the project manager at 541-687-7325.

Find information about requesting a review of DEQ project files at: http://www.deq.state.or.us/records/recordsRequestFAQ.htm

Find the File Review Application form at: http://www.deq.state.or.us/records/RecordsRequestForm.pdf

To access site summary information and other documents in the DEQ Leaking Underground Storage Tank Cleanup database, go to: http://www.deq.state.or.us/lq/tanks/lust/LustPublicLookup.asp

Enter 36-06-0382 in the "LUST Number" boxes and click "Lookup" at the bottom of the page. Next, click the link labeled 36-06-0382 in the Log Number column. Alternatively, you may go directly to the database website for this page at: http://www.deq.state.or.us/WebDocs/Forms/Output/LustOutput.aspx?SourceId=30193&SourceIdType=10

If you do not have web access and want to review the project file contact the DEQ project manager.

THE NEXT STEP: DEQ will review comments submitted by the noted deadline. If no comments are received or there is no objection to closure, DEQ will issue No Further Action to the Sheridan site.

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, call DEQ at 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.

PUBLIC NOTICE
PROPOSED NO FURTHER ACTION DETERMINATION, HOY'S MARINE SITE IN NEWPORT, OREGON

COMMENTS DUE: 5 p.m., Thursday, Sept. 1, 2016

PROJECT LOCATION: 4592 Yaquina Bay Road, Newport, OR

PROPOSAL: The Oregon Department of Environmental Quality invites comments on its proposal to issue a no further action determination for the Hoy's Marine Site.

HIGHLIGHTS: The Hoy's Marine Site consists of two adjacent tax lots totaling 0.45 acres on the east bank of the Yaquina River approximately 3 miles upstream of the Newport. The site was used as a shipyard from 1974 to 1999. Activities associated with site operations included shipbuilding, welding, sandblasting, painting and maintenance. Wastes generated during these operations included paint chips, paint residue containing heavy metals and tri-n-butyl tin, waste paint, paint thinner and petroleum.

Numerous investigations and cleanup actions were conducted from 1989 to 2015 by DEQ, the United States Environmental Protection Agency and various consultants. Site investigations documented contamination in the upland area and Yaquina River sediment. Contamination was related to ship maintenance activities, including sand blast operations conducted over the shoreline and shallow tidal flats. Contaminants included tri-n-butyl tin and metals such as copper, nickel and zinc.

Because responsible parties were unable to complete a cleanup, DEQ assumed the lead in site investigation and cleanup under terms of a Deferral Agreement with the EPA. Under terms of the agreement EPA agreed to defer listing of the Hoy's site on the National Priority List (also known as Superfund) provided DEQ complete appropriate cleanup actions.

In 1999 DEQ removed approximately 700 gallons of petroleum-containing liquids and approximately 150 gallons of paint waste and solvents from the site. Sandblast grit and associated stained soil also were removed. These wastes were either taken off site for recycling or were disposed of as hazardous waste.

In 2004 DEQ completed a sediment removal action that included dredging of contaminated sediment to the extent practical. Shallow bedrock conditions beneath the sediment layer prevented a complete removal of contaminated sediments. A total of 2,000 cubic yards of contaminated sediment were removed and disposed of in an upland repository on Port of Newport property in Newport. Due to funding

limitations DEQ was unable to complete additional risk assessment and report preparation at that time.

In 2014 DEQ initiated additional work at the site, including sediment, pore water, shellfish tissue, and bioassay tests and risk assessment. While sediment testing showed persistent levels of tri-n-butyl tin and metals in sediment, contaminants were not detected in shellfish samples, and bioassay samples indicated that the sediment did not adversely affect sediment dwelling organisms.

Based on these results DEQ concludes the site is protective of human health and the environment, and proposes to issue a no further action determination for the site. DEQ has obtained EPA concurrence that the site has met Deferral Agreement requirements and is protective of human health and the environment.

HOW TO COMMENT: Send comments to DEQ Project Manager Mark Pugh at 700 NE Multnomah St., Suite No. 600, Portland, OR 97232 or pugh.mark@deq.state.or.us. For more information contact the project manager at 503-229-5587.

Find information about requesting a review of DEQ project files

Find the File Review Application form.

To access site summary information and other documents visit the DEQ Environmental Cleanup Site Information Database, select "Search complete ECSI database", then enter 2082 in the Site ID box and click "Submit" at the bottom of the page. Next, click the link labeled 2082 in the Site ID/Info column. Alternatively, you may go directly to the Hoy's Marine website documents page.

If you do not have web access and want to review the project file contact the DEQ project manager.

THE NEXT STEP: DEQ will review and consider all comments received during the comment period prior to issuance of the no further action determination.

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 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 Chiropractic Examiners
Chapter 811

Rule Caption: Amendment updates the last adopted date of the Guide to Policy and Practice Questions
Stat. Auth.: ORS 684
Stats. Implemented: ORS 684.155
Proposed Amendments: 811-010-0093
Last Date for Comment: 8-15-16, 5 p.m.
Summary: Amendment updates the last adopted date of the Guide to Policy and Practice Questions
Rules Coordinator: Kelly J. Beringer
Address: Board of Chiropractic Examiners, 3218 Pringle Rd. SE, Suite 150, Salem, OR 97302
Telephone: (503) 373-1573

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Board of Examiners for Engineering and Land Surveying
Chapter 820

Rule Caption: Amend rules related to registration and advertising or offering professional services; housekeeping.
Stat. Auth.: ORS 670.310, 672.255
Stats. Implemented: ORS 672.002–672.325
Proposed Amendments: 820-010-0520, 820-010-0720, 820-025-0005, 820-040-0040
Last Date for Comment: 8-31-16, Close of Business
Summary: 820-010-0520 — Housekeeping; removing language related to the take-at-home examination no longer required and removing language inconsistent with OAR 820-010-0635 related to PDH units.

820-010-0720 — Amended language addresses "full-time" status and hours the registrant works along with bringing the language consistent with the exception in ORS 672.060(9). Amended language also removes reference to project offices and addresses the rule's inapplicability to licensed Construction Contractors.

820-025-0005 — Housekeeping; makes language consistent with OAR 820-025-0010(3)(f).

820-040-0040 — Housekeeping; removes the language that defines a Traffic Engineer and to contain language in the rule that solely defines the practice of Traffic Engineering.
Rules Coordinator: Jenn Gilbert
Address: Board of Examiners for Engineering and Land Surveying, 670 Hawthorne Ave. SE, Suite 220, Salem, OR 97301
Telephone: (503) 934-2107

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Board of Parole and Post-Prison Supervision
Chapter 255

Rule Caption: Procedures and number of Board members required for Board hearings and decisions.
Stat. Auth.: ORS 144.035, 144.054 & 144.110
Stats. Implemented: ORS 144.035, 144.054 & 144.110
Proposed Amendments: 255-030-0015
Last Date for Comment: 8-22-16, 5 p.m.
Summary: Amend number of Board of Parole members required to conduct a hearing and to make a final decision to conform rule with statutes, now that the Board has added additional members. This amendment would adopt as permanent temporary changes implemented on April 26, 2016.

The changes would eliminate the current conflict between what ORS 144.035, 144.054, and 144.110 expressly authorize and the more restrictive provisions of OAR 255-030-0015.

The 2015 legislature provided funding for 5 Board Member positions. Previously only 3 positions were funded. The legislature also amended ORS 144.035, 144.054, and 144.110 to harmonize those statutes with the Board's increased membership. Those statutes, collectively, allow the Board to use hearings panels consisting of 2 Board members to conduct its business; they also specify when no fewer than 3 Board members are necessary to reach a decision. However, the current version of OAR 255-030-0015, which governs how many Board members are necessary to conduct a hearing and to reach a decision, was written when there were only 3 Board members.

Consequently, the current rule is more restrictive than the current versions of ORS 144.054, and 144.110. As written, OAR 255-030-0015 now prohibits a panel of 2 Board members from conducting certain hearings that are expressly allowed under ORS 144.035. Additionally, ORS 144.054 expressly allows for 3 Board members to decide all murder, aggravated murders, and cases where death was involved. However, because the current rules were written for a 3-member board, they require that the "Full Board" must decide those cases. As a result, the Board's current rule prevents it from conducting those hearings in a manner that is both lawful and more efficient - i.e., with 3 members instead of the Full Board.
Rules Coordinator: Perry Waddell
Address: Board of Parole and Post-Prison Supervision, 2575 Center St. NE, Parole Suite 100, Salem, OR 97301
Telephone: (503) 945-0946

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Bureau of Labor and Industries
Chapter 839

Rule Caption: Modifies information to be included in wage statements provided to employees
Stat. Auth.: ORS 651.060(4), 653.040
Stats. Implemented: OL Ch. 115 (2016), S.B. 1587, 78th Leg., Reg. Session (Or.2016), ORS 653
Proposed Amendments: Rules in 839-020, 839-020-0012, 839-020-0080, 839-020-0083
Last Date for Comment: 8-21-16, 5 p.m.
Summary: The proposed rule amendments would conform the requirements of OAR 839-020-0012 (Wage Statements to Be Provided to Employees) and OAR 839-020-0083 (Records Availability) in the minimum wage rules to related provisions in OL Ch. 115 (2016), which take effect on January 1, 2017. The proposed rule

amendments would also correct an erroneous citation in OAR 839-020-0080.
Rules Coordinator: Marcia Ohlemiller
Address: Bureau of Labor and Industries, 800 NE Oregon St., Ste. 1045, Portland, OR 97232
Telephone: (971) 673-0784

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

Rule Caption: Uniform Alternate Construction Standards for One and Two Family Dwellings

Date:	Time:	Location:
8-16-16	9:30 a.m.	1535 Edgewater St. NW Salem, OR 97304

Hearing Officer: Staff
Stat. Auth.: ORS 455.610
Stats. Implemented: ORS 488.610
Proposed Adoptions: 918-480-0125
Proposed Repeals: 918-480-0100, 918-480-0110, 918-480-0120
Last Date for Comment: 8-19-16, 5 p.m.
Summary: This proposed rule is in response to updated legal guidance on the appropriate interpretation and implementation of ORS 455.610. The proposed rule implements the uniform alternative construction standards for one and two family dwellings required under ORS 455.610.
Rules Coordinator: Holly A. Tucker
Address: Department of Consumer and Business Services, Building Codes Division, PO Box 14470, Salem, OR 97309-0404
Telephone: (503) 378-5331

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Department of Consumer and Business Services, Finance and Securities Regulation
Chapter 441

Rule Caption: Commercial Construction Lending Exemption to Mortgage Loan Originator Licensing Requirements.

Date:	Time:	Location:
8-22-16	9 a.m.	Labor and Industries Bldg. Conference Rm. E 350 Winter St. NE Salem, OR 97301

Hearing Officer: Alex Cheng
Stat. Auth.: ORS 86A.242
Stats. Implemented: ORS 86A.203
Proposed Adoptions: 441-880-0009
Last Date for Comment: 8-29-16, 5 p.m.
Summary: The Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (S.A.F.E. Act), 12 U.S.C. § 5101 et seq., requires states to license "loan originators" who are individuals that take a residential mortgage loan application and offer or negotiate terms of a "residential mortgage loan" for compensation or gain. The S.A.F.E. Act defines "residential mortgage loan" as "any loan primarily for personal, family, or household use that is secured by a mortgage, deed of trust, or other equivalent consensual security interest on a dwelling... or residential real estate upon which is constructed or intended to be constructed a dwelling (as so defined)."

To carry out the S.A.F.E. Act, ORS 86A.203 requires individuals engaged in business as a mortgage loan originator to obtain a license from DCBS. Subsection (5) grants authority to the DCBS Director to exempt an individual from the licensing requirement if the U.S. Consumer Financial Protection Bureau permits the exemption under 12 U.S.C. § 5101 et seq. Federal law only requires licensing for individual who deal in loans primarily for personal, family, or household use. This proposed rule would exempt lenders who make commercial construction loans from this licensing requirement under certain circumstances. To qualify for the exemption under this rule, a lender would have to verify that the borrower is a licensed general contractor, verify that the loan is for a business purpose and will be used to construct a residential structure, and refrain from certain other prohibited activities.
Rules Coordinator: Shelley Greiner
Address: Department of Consumer and Business Services, Finance and Securities Regulation, 350 Winter St. NE, Rm. 410, Salem, OR 97301
Telephone: (503) 947-7484

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Department of Consumer and Business Services, Health Insurance Marketplace
Chapter 945

Rule Caption: Establishes Requirements of COFA Premium and Cost-Sharing Payment Assistance Program

Date:	Time:	Location:
8-25-16	1:30 p.m.	Labor & Industries Bldg., Rm. F 350 Winter St. NE Salem, 97301

Hearing Officer: Victor Garcia
Stat. Auth.: OL 2016, Ch. 94
Stats. Implemented: OL 2016, Ch. 94
Proposed Adoptions: Rules in 945-050, 945-060
Last Date for Comment: 8-26-16, Close of Business
Summary: These rules establish the requirements for participation in the COFA Premium and Cost-Sharing Assistance Program mandated by Oregon Laws 2016, Chapter 94. The rules define necessary terms, both those used in the statute and those used in the rules. The rules set out the time line for submission of an application to participate in the program, authorize the department to obtain the necessary information from third parties to verify eligibility in the program and eligibility for reimbursement, set out the requirements applicable to the department related to its processing of applications and payment of cost-sharing and premiums, and provide appeal rights to program applicants and participants subject to an adverse decision by the department.
Rules Coordinator: Victor Garcia
Address: Department of Consumer and Business Services, Health Insurance Marketplace, 350 Winter St. NE, Salem, OR 97301
Telephone: (971) 283-1878

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Department of Consumer and Business Services, Oregon Occupational Safety and Health Division
Chapter 437

Rule Caption: Adopt federal OSHA amendments: Occupational Exposure to Respirable Crystalline Silica in General Industry, Construction, Maritime.

Date:	Time:	Location:
8-25-16	10 a.m.	Oregon OSHA, Durham Plaza 16760 SW Upper Boones Ferry Rd. Suite 200 Tigard, OR 97224
8-30-16	11 a.m.	Oregon OSHA, Red Oaks Square 1230 NE Third St., Suite A-115 Bend, OR 97701-4374
9-8-16	10 a.m.	Oregon OSHA 1140 Willagillespie Rd., Suite 42 Eugene, OR 97401-6730
9-9-16	10 a.m.	City of Medford, Lausmann Annex 200 S Ivy, Rm. 151, Medford, OR 97501

Hearing Officer: Sue Joye
Stat. Auth.: ORS 654.025(2), 656.726(4)
Stats. Implemented: ORS 654.001–654.295
Proposed Adoptions: 437-002-1053, 437-002-1054, 437-002-1055, 437-002-1056, 437-002-1057, 437-002-1058, 437-002-1059, 437-002-1060, 437-002-1061, 437-002-1062, 437-002-1063, 437-002-1064, 437-002-1065
Proposed Amendments: 437-002-0382, 437-003-1000, 437-005-0001

Last Date for Comment: 9-16-16, 5 p.m.
Summary: This rulemaking is to keep Oregon OSHA in harmony with recent changes to Federal OSHA's standards.

On March 25, 2016, federal OSHA adopted final rules for crystalline silica for general industry, construction, and maritime. Before these rules, the only specific rule for crystalline silica was an airborne permissible exposure limit (PEL) of 100 micrograms per cubic meter of air (μg/m3). With the adoption of these rules, federal OSHA lowered the PEL from 100 μg/m3 to 50 μg/m3, and instituted an action level of 25 μg/m3. These rules require an exposure assessment, with periodic monitoring under certain circumstances, requires engineering and work practice controls to reduce exposure levels, institutes a written exposure control plan, requires provisions for regulating employee access to certain areas, respiratory protection, medical surveillance, and employee training and information. The construction rule also lists specific tasks with engineering controls, work practice controls, and respiratory protection for specific tasks that do not require an exposure assessment, and requires that a competent person ensure that the written program and specific tasks are followed.

Oregon OSHA proposes to combine the requirements of the general industry and construction rules into one set of rules applicable to both industries, as new Oregon-initiated rules OAR 437-002-1053 through 437-002-1065. These Oregon initiated rules provide the same options for construction employers to use certain specified methods in lieu of an exposure assessment as the federal rules, and maintain the same compliance dates as the federal standards.

Oregon OSHA also proposes to update the air contaminants rules for general industry and construction, OAR 437-002-0382 and 437-003-1000, to reflect the new silica rules.

Please visit our web site osha.oregon.gov

Click 'Rule changes' in the Topics, rules, guidelines column and view our proposed rules; or, select other rule activity from the left vertical column on the Proposed Rules page.

Rules Coordinator: Sue C. Joye
Address: Department of Consumer and Business Services, Oregon Occupational Safety and Health Division, 350 Winter St. NE , Salem, OR 97301-3882
Telephone: (503) 947-7449

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Department of Consumer and Business Services, Workers' Compensation Division
Chapter 436

Rule Caption: Training, certification, and employment of claims examiners

Date:	Time:	Location:
8-23-16	9 a.m.	Labor & Industries Bldg., Rm. F 350 Winter St. NE Salem, OR

Hearing Officer: Fred Bruyns
Stat. Auth.: ORS 656.726, 656.780
Stats. Implemented: ORS 656.780
Proposed Amendments: 436-055-0003, 436-055-0005, 436-055-0008, 436-055-0070, 436-055-0085, 436-055-0100, 436-055-0110
Proposed Repeals: 436-055-0001, 436-055-0002
Last Date for Comment: 8-29-16, Close of Business
Summary: The public may also listen to the hearing or testify by telephone:

Dial-in number is 1-213-787-0529; Access code is 9221262#.

Proposed amendments to OAR 436-055, "Certification of Claims Examiners" include:

- Repeal of obsolete or redundant rules, and deletion of obsolete, redundant, or erroneous rule text;
- Revision and reorganization, including consolidation, of rules to enhance clarity, ease of reading, and consistency;
- Revision of definitions, including the definition of "process claims";
- Clarification of the insurer's responsibilities related to renewal of claims examiner certification;
- Reduction of the required number of training hours related to interactions with independent medical examination providers for renewal of claims examiner certification from three hours to one hour;
- Increase in the required number of training hours related to rules, statutes, and case law for renewal of claims examiner certification from four hours to six hours;
- Addition of some record-keeping requirements currently published on an agency website;
- Insertion of rule wording, inadvertently deleted during previous rulemaking, while removing obsolete elements;
- Clarification of an insurer's responsibility to issue certificates, acknowledge certifications from other insurers, and verify documentation that requirements have been met;
- Clarification of the roles and qualifications of a claims examiner trainee and a temporary claims examiner;
- Allowing a person who has not been certified for more than one year to be hired as a trainee;
- Allowing a person whose certification has lapsed for one year or less to renew certification if training requirements have been met; and
- Clarification that nothing in the rules precludes an insurer from providing additional training.

Rules Coordinator: Fred Bruyns
Address: Department of Consumer and Business Services, Workers' Compensation Division, PO Box 14480, Salem, OR 97309-0405
Telephone: (503) 947-7717

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Department of Environmental Quality
Chapter 340

Rule Caption: Water Quality Standards for Copper 2016

Date:	Time:	Location:
8-30-16	6 p.m.	DEQ Headquarters 811 SW 6th Ave. 10th Floor, Rm. EQC A Portland, OR
8-31-16	2 p.m.	DEQ Headquarters 811 SW 6th Ave. 10th Floor, Rm. EQC A Portland, OR

Hearing Officer: DEQ Staff
Stat. Auth.: ORS 468.020, 468B.030, 468B.035, 468B.048
Stats. Implemented: ORS 468B.030, 468B.035, 468B.048
Proposed Amendments: 340-041-0033, 340-041-8033
Last Date for Comment: 9-15-16, 4 p.m.
Summary: The U. S. Environmental Protection Agency disapproved Oregon's water quality criteria for copper in 2013. DEQ is proposing to adopt copper criteria to negate a need for the EPA to adopt copper criteria for Oregon. The proposed rule amendments will:

- Revise Oregon's water quality criteria for copper to protect freshwater aquatic life. The revised criteria are based on the U.S. Environmental Protection Agency's 2007 national recommendation to use the Biotic Ligand Model to derive site-specific criteria based on the water chemistry of a site that affects the bioavailability and toxicity of copper to aquatic life in fresh waters.
- Address EPA's January Jan. 31, 2013, disapproval of Oregon's current copper criteria in response to a National Marine Fisheries Service's Biological Opinion that concluded the current criteria would cause jeopardy to threatened and endangered species.

Rules Coordinator: Meyer Goldstein
Address: Department of Environmental Quality, 811 SW Sixth Ave., Portland, OR 97204
Telephone: (503) 229-6478

Department of Fish and Wildlife
Chapter 635

Rule Caption: Amend and Adopt Rules for Forage Fish Management Plan Implementation.

Date:	Time:	Location:
9-2-16	8 a.m.	Resort at the Mountain Hunchback Conference Rm. 68010 East Fairway Ave. Welches, OR 97067-9706

Hearing Officer: OR Fish and Wildlife Commission
Stat. Auth.: ORS 496, 506, 508
Stats. Implemented: ORS 496, 506, 508
Proposed Adoptions: Rules in 635-003, 635-004, 635-005, 635-006
Proposed Amendments: Rules in 635-003, 635-004, 635-005, 635-006
Proposed Repeals: Rules in 635-003, 635-004, 635-005, 635-006
Last Date for Comment: 9-2-16, Close of Hearing
Summary: Amendments to Oregon's regulations for commercial fisheries will bring the State concurrent with federally adopted regulations to provide additional protections to selected forage fish species in federal waters. These protections include trip-level and annual landing limits by vessels for Oregon ports and annual processing limits by at-sea and shore-based whiting fisheries. Consistent with a proposed new Oregon Forage Fish Management Plan, amendments to Oregon's regulations will also extend similar protections for forage fish species in State waters and apply to all commercial fishing vessels in the State's marine and brackish waters. The applicable State forage fish species include Pacific sand lance, Pacific saury, mesopelagic fishes (four families), osmerid smelts, silversides, and pelagic squids, excluding market squid and Humboldt squid. Two herring species are included under federal protections but do not occur in Oregon waters. These forage fish species have not been subject to direct commercial fishing in state or federal waters off Oregon. Proposed rules prohibit new directed commercial fisheries for these species and limit bycatch in other fisheries in order to support existing fisheries and ecosystem function. Proposed rules modify fish ticket requirements in order to improve tracking of commercial fisheries landings of these species. Housekeeping and technical corrections to the regulations may occur to ensure rule consistency.
Rules Coordinator: Michelle Tate
Address: Department of Fish and Wildlife, 4034 Fairview Industrial Dr. SE, Salem, OR 97302
Telephone: (503) 947-6044

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

Rule Caption: Homecare Workers Enrolled in the Consumer-Employed Provider Program

Date:	Time:	Location:
8-15-16	1 pm.	Human Service Bldg. 500 Summer St. NE, Rm. 160 Salem, OR 97301

Hearing Officer: Staff
Stat. Auth.: ORS 409.050, 410.070, 410.090
Other Auth.: S.B. 622 (2015)
Stats. Implemented: ORS 125.050, 125.065, 183.310, 410.010, 410.020, 410.070, 410.612, 410.614, 653.025
Proposed Amendments: 411-031-0020, 411-031-0030, 411-031-0040, 411-031-0050
Proposed Repeals: 411-031-0020(T), 411-031-0040(T), 411-031-0050(T)
Last Date for Comment: 8-21-16, 5 p.m.
Summary: The Department of Human Services (Department) is amending OAR 411-031 to make permanent temporary changes that were implemented in March 2016 that bring the rules into compliance with new federal and state law and collective bargaining requirements in regards to homecare workers. The proposed rule changes:

- Permit the Department to begin calculating, tracking, and paying homecare workers for travel time between consumer-employers. This is a new requirement mandated by the United States Department of Labor (DOL) and the 2015-2019 Collective Bargaining Agreement between the Oregon Home Care Commission and the Service Employees International Union, Local 503, OPEU.
- Enable the Department to comply with Senate Bill 622, which adds homecare workers to the list of "Mandatory Reporters". The rules establish reporting standards and a process for what happens if a homecare worker does not report as they are required to do.
- Permit homecare workers to appeal terminations of their provider enrollment more quickly and to proceed to administrative hearing more easily than the current process allows. These temporary rules bring the Department into compliance with ORS 183.310.
- Update the language on the trusts process;
- Delete language in regards to benefits; and
- Minor grammar, formatting, and housekeeping changes were done to align the rules with other current program rule and definition changes.

Written comments may be submitted via e-mail to Kimberly.Colkitt-Hallman@state.or.us or mailed to 500 Summer Street NE, E48 Salem, Oregon, 97301-1064. All comments received will be given equal consideration before the Department proceeds with the permanent rulemaking.
Rules Coordinator: Kimberly Colkitt-Hallman
Address: Department of Human Services, Aging and People with Disabilities and Developmental Disabilities, 500 Summer St. NE, E48, Salem, OR 97301
Telephone: (503) 945-6398

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Department of Human Services,
Child Welfare Programs
Chapter 413

Rule Caption: Amending rule about when the Department may waive the home study requirement for independent adoptions
Stat. Auth.: ORS 109.309, 409.050, 418.005
Stats. Implemented: ORS 109.309, 409.010, 409.050, 418.005
Proposed Amendments: 413-140-0032
Proposed Repeals: 413-140-0032(T)
Last Date for Comment: 8-26-16, 5 p.m.
Summary: The Department of Human Services is proposing to amend OAR 413-140-0032 to allow the Department to waive the home study requirement when the birth mother retains parental rights as allowed under ORS 109.309(7)(b). This makes permanent temporary rules adopted on April 26, 2016.

In addition, non-substantive edits may be made to: ensure consistent terminology throughout child welfare program rules and policies; make general updates consistent with current Department practices; update statutory and rule references; correct formatting and punctuation; improve ease of reading; and clarify Department rules and processes.

Rule text showing edits is available at http://www.dhs.state.or.us/policy/childwelfare/drafts/drafts.htm.
Rules Coordinator: Kris Skaro
Address: Department of Human Services, Child Welfare Programs, 500 Summer St. NE, E-48, Salem, OR 97301
Telephone: (503) 945-6067

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Rule Caption: Amending rule about Department notification responsibilities when screening and assessing reports of child abuse
Stat. Auth.: ORS 418.005, 419B.017
Stats. Implemented: ORS 418.005, 419B.015, 419B.017
Proposed Amendments: 413-015-0215, 413-015-0415
Proposed Repeals: 413-015-0215(T), 413-015-0415(T)

Last Date for Comment: 8-26-16, 5 p.m.
Summary: The Department of Human Services, Office of Child Welfare Programs, is proposing to amend Child Safety Program (CPS) rules to clarify when CPS staff must notify the Office of Adult Abuse Prevention and Investigations (OAAPI) and the Office of Developmental Disabilities Services (ODDS) about reports of child abuse or neglect that involve children with intellectual or developmental disabilities. (The change to OAR 413-015-0215 was adopted by temporary rule on April 11, 2016.)

Rule text showing edits is available at http://www.dhs.state.or.us/policy/childwelfare/drafts/drafts.htm.
Rules Coordinator: Kris Skaro
Address: Department of Human Services, Child Welfare Programs, 500 Summer St. NE, E-48, Salem, OR 97301
Telephone: (503) 945-6067

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Department of Human Services,
Self-Sufficiency Programs
Chapter 461

Rule Caption: Establishing the general assistance project as required by HB 4042 (2016)

Date:	Time:	Location:
8-22-16	1 p.m.	500 Summer St. NE, Rm. 255 Salem, OR 97301

Hearing Officer: Kris Skaro
Stat. Auth.: ORS 409.050, 411.060 & 411.070
Stats. Implemented: ORS 409.050, 411.060, 411.070 & Or Laws 2016, ch 93
Proposed Amendments: 461-001-0000, 461-101-0010, 461-110-0630, 461-110-0750, 461-115-0030, 461-115-0050, 461-115-0071, 461-115-0430, 461-115-0700, 461-120-0030, 461-120-0125, 461-120-0210, 461-120-0315, 461-120-0345, 461-120-0350, 461-120-0510, 461-125-0810, 461-135-0560, 461-135-0700, 461-135-0701, 461-135-0708, 461-135-0950, 461-135-0990, 461-140-0010, 461-140-0040, 461-140-0120, 461-140-0210, 461-140-0242, 461-140-0250, 461-140-0296, 461-140-0300, 461-145-0005, 461-145-0040, 461-145-0050, 461-145-0110, 461-145-0220, 461-145-0230, 461-145-0240, 461-145-0250, 461-145-0259, 461-145-0260, 461-145-0320, 461-145-0330, 461-145-0340, 461-145-0360, 461-145-0365, 461-145-0370, 461-145-0410, 461-145-0420, 461-145-0455, 461-145-0460, 461-145-0470, 461-145-0510, 461-145-0540, 461-145-0600, 461-145-0910, 461-145-0920, 461-145-0930, 461-150-0050, 461-155-0010, 461-155-0020, 461-155-0210, 461-155-0360, 461-155-0580, 461-155-0600, 461-155-0610, 461-155-0620, 461-155-0640, 461-155-0670, 461-160-0010, 461-160-0015, 461-160-0055, 461-160-0060, 461-160-0500, 461-160-0620, 461-165-0030, 461-165-0050, 461-165-0120, 461-170-0011, 461-175-0210, 461-175-0240, 461-175-0310, 461-180-0010, 461-180-0065, 461-180-0070, 461-180-0090, 461-195-0521, 461-195-0541
Proposed Repeals: 461-001-0000(T), 461-101-0010(T), 461-110-0390, 461-110-0630(T), 461-110-0750(T), 461-115-0030(T), 461-115-0050(T), 461-115-0071(T), 461-115-0430(T), 461-115-0700(T), 461-120-0030(T), 461-120-0125(T), 461-120-0210(T), 461-120-0315(T), 461-120-0345(T), 461-120-0350(T), 461-120-0510(T), 461-125-0510, 461-125-0810(T), 461-135-0560(T), 461-135-0700(T), 461-135-0701(T), 461-135-0705, 461-135-0708(T), 461-135-0950(T), 461-135-0990(T), 461-140-0010(T), 461-140-0040(T), 461-140-0120(T), 461-140-0210(T), 461-140-0242(T), 461-140-0250(T), 461-140-0296(T), 461-140-0300(T), 461-145-0005(T), 461-145-0040(T), 461-145-0050(T), 461-145-0110(T), 461-145-0220(T), 461-145-0230(T), 461-145-0240(T), 461-145-0250(T), 461-145-0259(T), 461-145-0260(T), 461-145-0320(T), 461-145-0330(T), 461-145-0340(T), 461-145-0360(T), 461-145-0365(T), 461-145-0370(T), 461-145-0410(T), 461-145-0420(T), 461-145-0455(T), 461-145-0460(T), 461-145-0470(T), 461-145-0510(T), 461-145-0540(T), 461-145-0600(T), 461-145-0910(T), 461-145-0920(T), 461-145-0930(T), 461-150-0050(T), 461-155-0010(T), 461-155-0020(T), 461-155-0210(T), 461-155-0360(T), 461-155-0580(T), 461-155-0600(T), 461-155-0610(T), 461-155-0620(T), 461-155-0640(T), 461-155-0670(T), 461-160-0010(T), 461-160-0015(T), 461-160-0055(T), 461-160-0060(T), 461-160-0500(T), 461-160-0620(T), 461-165-0030(T), 461-165-0050(T), 461-165-0120(T), 461-170-0011(T), 461-175-0210(T), 461-175-0240(T), 461-175-0310(T), 461-180-0010(T), 461-180-0065(T), 461-180-0070(T), 461-180-0090(T), 461-195-0521(T), 461-195-0541(T)
Last Date for Comment: 8-26-16, 5 p.m.
Summary: The Department of Human Services is reestablishing the GA (General Assistance) program to comply with HB 4042 (2016). The program provides cash assistance to individuals who have a disability, are experiencing homelessness, and meet other eligibility requirements in OAR 461-135-0700. Rules throughout OAR chapter 461 are also being amended to remove all references to the GAM (General Assistance - Medical) program and remove references to GA when applicable. This makes permanent temporary rules adopted on July 1, 2016.

In addition, non-substantive edits may be made to: ensure consistent terminology throughout self-sufficiency program rules and policies; make general updates consistent with current Department practices; update statutory and rule references; correct formatting and punctuation; improve ease of reading; and clarify Department rules and processes.

Rule text showing edits for the rules described above is available at http://www.dhs.state.or.us/policy/selfsufficiency/ar_proposed.htm.
Rules Coordinator: Kris Skaro
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: Amending rules relating to public and medical assistance programs

Date:	Time:	Location:
8-22-16	1 p.m.	500 Summer St. NE, Rm. 255 Salem, OR 97301

Hearing Officer: Kris Skaro
Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 413.042, 413.085, 414.231, 416.340, 416.350
Other Auth.: 42 CFR 435.403, Social Security Act 1902e(12)
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.706, 413.042, 413.085, 414.231, 416.340, 416.350, Oregon Laws 2016, chapter 93
Proposed Amendments: 461-120-0030, 461-135-0010, 461-135-0835, 461-160-0015, 461-180-0040
Last Date for Comment: 8-26-16, 5 p.m.
Summary: OAR 461-120-0030 about the state of residence for an individual in a medical facility is being amended to change the criteria for determining the state of residence in the Oregon Supplemental Income Program Medical (OSIPM), the Qualified Medicare Beneficiary (QMB) program, and the Refugee Medical (REFM) program to align with federal policy. It is also being amended to remove a reference to General Assistance Medical (GAM).

OAR 461-135-0010 about assumed eligibility for medical programs is being amended to clarify that in the OSIPM program, continuous eligibility for children can apply at initial eligibility and at redetermination. It is also being amended to state that continuous eligibility does not apply if the child is eligible for any other Medicaid program that provides OHP Plus benefits. Previously there was no requirement that other programs be evaluated prior to providing continuous coverage under OSIPM.

OAR 461-135-0835 about limits on estate claims is being amended to clarify which Department personnel are authorized to present, file, and resolve estate recovery claims. It is also amended to authorize Estate Administration Unit managers to designate additional personnel with the authority to present, file, or resolve estate recovery claims. The rule is also amended to exclude, consistent with ORS 411.795 as amended by HB 4042 (2016), a claim against an estate for benefits correctly paid under HB 4042.

OAR 461-160-0015 about resource limits is being amended to align the Department with federal policy regarding the resource limits for QMB-DW and eliminate an outdated reference to OSIP resource limits.

OAR 461-180-0040 about effective dates for special or service needs is being amended to clarify that eligibility for special needs and services is contingent on OSIPM and OHP Plus eligibility. Specifically, the rule is amended to state that the effective date for a special need is either the date of request for the special need item or the effective date for OSIPM, whichever is later, and that the effective date for long-term care is the date for Department authorizes the service plan, except that the service plan may not be authorized prior to the effective date for Medicaid OHP Plus benefit package.

In addition, non-substantive edits may be made to these rules to: ensure consistent terminology throughout self-sufficiency program rules and policies; make general updates consistent with current Department practices; update statutory and rule references; correct formatting and punctuation; improve ease of reading; and clarify Department rules and processes.

Rule text showing edits for the rules described above is available at http://www.dhs.state.or.us/policy/selfsufficiency/ar_proposed.htm.
Rules Coordinator: Kris Skaro
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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Department of Revenue
Chapter 150

Rule Caption: Marijuana Tax: Establishes permanent rules for marijuana tax and medical marijuana cardholder tax exemption provisions.

Date:	Time:	Location:
8-23-16	9 a.m.	Revenue Bldg., Fishbowl Conference Rm. 955 Center St NE Salem, OR 97303

Hearing Officer: Shannon Ball
Stat. Auth.: ORS 305.100; 475B.750
Stats. Implemented: ORS 475B.705; 475B.720; 475B.740; Section 2, Chapter 91, Oregon Laws 2016
Proposed Adoptions: 150-475-2080, 150-475-2090
Proposed Repeals: 150-475B.705(T)
Proposed Ren. & Amends: 150-475B.720 to 150-475-2050
Last Date for Comment: 8-23-16, 5 p.m.
Summary: 150-475-2080 — Makes permanent retailer receipting requirements so that the department can administer the refund provisions in ORS 475B.740, if tax rates change.

150-475-2090 — Establishes procedures for marijuana retailers to verify validity of medical marijuana tax exemptions.

150-475B.705 Temporary — Will be replaced by permanent rule 150-475-2080 effective 10/1/2016.

150-475B.720 amended and renumbered to 150-475-2050 — Modifies existing model recordkeeping rule to include provisions relating to retention of medical marijuana tax exemption information.
Rules Coordinator: Lois Williams
Address: Department of Revenue, 955 Center St. NE, Salem, OR 97301
Telephone: (503) 945-8029

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Department of Transportation
Chapter 731

Rule Caption: Road Usage Charge Program
Stat. Auth.: ORS 184.616, 184.619, 319.905, 319.910, 319.925, 319.930
Stats. Implemented: ORS 319.883–319.990
Proposed Amendments: 731-090-0000, 731-090-0020, 731-090-0030, 731-090-0040, 731-090-0070, 731-090-0080, 731-090-0090
Last Date for Comment: 8-22-16, 8:30 a.m.
Summary: To further clarify the existing administrative rules for the administration, operations and compliance of the Road Usage Charge Program. The Program is a volunteer program authorized under Chapter 781, Oregon Laws 2013 for the purpose of establishing an alternative revenue source to the state fuels tax.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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

Rule Caption: Driving Privileges — Application, Testing, Qualifications, Restrictions and Relating Provisions for Commercial and Non-Commercial Privileges

Date:	Time:	Location:
8-17-16	10 a.m.	DMV Headquarters, Rm. 122 1905 Lana Ave NE Salem OR

Hearing Officer: Liz Woods
Stat. Auth.: ORS 184.616, 184.619, 192.440, 802.010, 802.012, 802.179, 802.183, 802.200, 802.210, 802.220, 802.230, 802.540, 803.350, 803.370, 807.021, 807.022, 807.024, 807.040, 807.045, 807.050, 807.060, 807.062, 807.070, 807.072, 807.080, 807.100, 807.110, 807.120, 807.130, 807.150, 807.160, 807.170, 807.173, 807.220, 807.230, 807.310, 807.368, 807.400, 809.310, 809.415, 809.419, 809.480, 809.520, 809.525, 809.605, 821.080
Other Auth.: 49 CFR secs. 381.300-381.330, 383.51, 383.71, 383.110-383.123, 383.131-383.135, 391.41-391.49 and 49 USC sec. 5103a
Stats. Implemented: ORS 746.265, 801.163, 802.012, 802.200, 802,220, 802.230, 802.500, 802.520, 802.540, 803.200, 803.300, 803.325, 803.350, 803.355, 803.360, 803.370, 807.010, 807.018, 807.021, 807.022, 807.024, 807.031, 807.035, 807.040, 807.045, 807.050, 807.060, 807.062, 807.066, 807.070, 807.072, 807.080, 807.100, 807.110, 807.120, 807.130, 807.150, 807.160, 807.170, 807.173, 807.220, 807.230, 807.240, 807.270, 807.280, 807.285, 807.310, 807.350, 807.355, 807.359, 807.363, 807.368, 807.369, 807.400, 809.135, 809.310, 809.360, 809.380, 809.400, 809.411, 809.415, 809.419, 809.430, 809.480, 809.510-809.545, 809.600(2), 809.605, 821.080, 825.410, 825.412, 825.415, 825.418, 826.033
Proposed Adoptions: 735-062-0001, 735-062-0087, 735-063-0200, 735-063-0250, 735-063-0260, 735-063-0270, 735-063-0280, 735-063-0300, 735-063-0370
Proposed Amendments: 735-010-0030, 735-016-0060, 735-016-0070, 735-062-0002, 735-062-0005, 735-062-0007, 735-062-0016, 735-062-0030, 735-062-0032, 735-062-0070, 735-062-0080, 735-062-0090, 735-062-0110, 735-062-0125, 735-062-0300, 735-062-0310, 735-062-0330, 735-064-0220, 735-064-0230, 735-064-0235
Proposed Repeals: 735-062-0075, 735-062-0150, 735-062-0200
Proposed Ren. & Amends: 735-062-0190 to 735-063-0290, 735-062-0210 to 735-063-0310, 735-063-0000 to 735-063-0205, 735-063-0050 to 735-063-0210, 735-063-0060 to 735-063-0220, 735-063-0065 to 735-063-0230, 735-063-0070 to 735-063-0240, 735-070-0185 to 735-063-0320, 735-070-0190 to 735-063-0330, 735-063-0067 to 735-063-0340, 735-063-0075 to 735-063-0350, 735-063-0130 to 735-063-0360, 735-063-0180 to 735-063-0380
Last Date for Comment: 8-22-16, 8:30 a.m.
Summary: Effective September 26, 2016, DMV will issue a Commercial Learner Permit (CLP) in accordance with ORS 807.285 and 49 CFR 384.204. The eligibility requirements, qualifications, testing procedures, endorsements and restrictions to be issued a CLP or commercial driver license (CDL) are different than those necessary to be issued a Class C non-commercial instruction permit, driver license, driver permit or identification card. Therefore, this rulemaking attempts to clearly delineate those differences by separating provisions of administrative rules that are specific to commercial

driving privileges and consolidate them into OAR chapter 735, division 63, and removing provisions specific to commercial driving privileges from chapter 735, division 62. The proposed expanded OAR chapter 735, division 63, also includes details regarding violations committed when operating a commercial motor vehicle or holding commercial driving privileges, sanctions, and options to regain commercial driving privileges. Once a person is issued a CLP, that person has commercial driving privileges and is subject to the various provisions of having commercial driving privileges the same as a person who has a CDL. Therefore, one of the amendments proposed in this rulemaking is to use the terminology "commercial driving privileges" consistently throughout these rules.

The following rules are repealed, amended, or renumbered and amended simply to conform with the purposes described above: The proposed rules to be repealed: OAR 735-062-0075, 735-062-0150, and 735-062-0200. The proposed amendment of: OAR 735-010-0030, 735-062-0002, 735-062-0005, 735-062-0007, 735-062-0032, 735-062-0070, 735-062-0080, 735-062-0090, 735-062-0110, 735-062-0125, 735-064-0220, 735-064-0230 and 735-064-0235. The proposed renumbering and amendment of: 735-062-0190 to 735-063-0290; 735-062-0210 to 735-063-0310; 735-070-0185 to 735-063-0320 and 735-070-0190 to 735-063-0330.

The following rules are renumbered in a logical order and amended to conform with other rule changes as OAR Chapter 735, Division 63 was expanded: 735-063-0000 to 735-063-0205, 735-063-0050 to 735-063-0210, 735-063-0060 to 735-063-0220 and 735-063-0065 to 735-063-0230; 735-063-0067 to 735-063-0340; 735-063-0130 to 735-063-0360; and 735-063-0180 to 735-063-0380.

Specific proposed changes to rules include:

Proposed adoption of OAR 735-062-0001 and 735-063-0200 - These two rules outline the purpose to their specific rule divisions, explaining the distinction between non-commercial and commercial driving privileges. OAR 735-063-0200 further establishes which rule provisions in OAR chapter 735, division 62 (such as renewal), apply to commercial driving privileges.

Proposed adoption of OAR 735-063-0250 establishes the knowledge testing and issuance requirements for a CLP.

Proposed adoption of OAR 735-063-0260 establishes the testing and issuance requirements for a CDL.

Proposed adoption of OAR 735-063-0270 establishes when DMV will accept CDL skills tests scores if a person with an Oregon CLP trains and tests out of state.

Proposed adoption of OAR 735-063-0280 captures the process previously outlined in OAR 735-062-0080 regarding waiving the CDL skills test for an applicant who gained experience driving commercial motor vehicles while in the military, when certain criteria are met.

Proposed adoption of 735-063-0300 establishes the restrictions that DMV may place on commercial driving privileges. This rule combines restrictions currently listed in OAR 735-063-0067 and 735-062-0150 with restrictions not previously delineated in rule.

This rulemaking also takes the opportunity to make small amendments to other rules that DMV has identified as follows:

Proposed amendments to OAR 735-016-0060 and 735-016-0070 conform rule language to current DMV practice regarding residency/domicile issues.

Proposed amendment to OAR 735-062-0016 authorizing DMV to make a copy of the document(s) a person presents when trying to prove his or her identity, allows DMV to thoroughly review the document(s) and complete any additional research needed to determine the identity of the person for whom DMV could not establish during the biometric check.

Proposed amendment to OAR 735-062-0030 clarifies what DMV may accept as proof of residence address and relates to the proposed changes in OAR 735-016-0060 and 735-016-0070.

Proposed adoption of OAR 735-062-0085 establishes in rule restrictions that DMV may place on a non-commercial Class C driver license or driver permit.

Proposed amendment of OAR 735-062-0300 and 735-062-0310 is to update a reference to Oregon law that has since been codified and to correct a reference to a range of rule numbers.

Proposed amendment of OAR 735-062-0330 is to allow a person who is experienced in driving with the use of bioptic telescopic lens in another state to qualify in Oregon by taking less than the same amount of training as a driver who has never driven using the device.

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,
Motor Carrier Transportation Division
Chapter 740

Rule Caption: SB 142A Deregulation of passenger carriage transportation
Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 805.300, 818.200, 818.210, 818.230, 823.007, 823.029, 825.100, 825.102, 825.104, 825.106, 825.108, 825.110, 825.115, 825.135, 825.160, 825.166, 825.200, 825.202, 825.204, 825.206, 825.220, 825.224, 825.234, 825.240, 825.320, 825.470, 825.950, 826.031
Proposed Amendments: 740-020-0010, 740-030-0010, 740-035-0010, 740-035-0145, 740-035-0150, 740-035-0165, 740-045-0110, 740-050-0010, 740-050-0020, 740-050-0050, 740-050-0100, 740-050-0110, 740-050-0120, 740-050-0140, 740-050-0220, 740-050-0230, 740-050-0500, 740-050-0600, 740-050-0610, 740-050-0630, 740-050-0820, 740-050-0830, 740-055-0150, 740-055-0170, 740-055-0190, 740-055-0210, 740-055-0500, 740-300-0040
Proposed Repeals: 740-035-0160, 740-050-0070, 740-050-0080, 740-050-0090, 740-050-0130, 740-050-0210, 740-050-0270, 740-050-0400, 740-050-0410, 740-050-0430, 740-055-0310
Last Date for Comment: 8-22-16, 8:30 a.m.
Summary: The proposed rulemaking is necessary to implement SB 142A. Regular route passenger carriage remains subject to full economic regulation including entry, rates and routes. The purpose behind state economic regulation historically has been to ensure the statewide availability of a reliable level of service while neither allowing service providers to realize excess profits as a sponsored monopoly or risk going under due to declining revenues insufficient to maintain a viable fleet and level of service.

There is a declining population of motor carriers possessing certificated authority to provide regular route passenger transportation subject to economic regulation and the simultaneous growth of public transit providers of the same passenger carrier services. Currently, these two models are sometimes bumping up against existing statutory economic regulation requirements which were unknown to them when they commenced operations. That fact has given rise to certain protestations from private providers of passenger carriage which find it difficult to compete with publicly provided competition. Today, there are only 11 motor carriers in Oregon that hold certificated authority to transport passengers. Of 11 passenger carriers with certificated authority, three are inactive, one was purchased by another, and three of them are receiving public transit subsidies either in the form of a route, fares, or equipment.

By deleting the barriers to entry and the requirements of rate regulation Senate Bill 142 seeks to enable public transportation entities to advance and continue their provision of services. Existing private providers will have opportunity to assist in provided contracted passenger carriage services for public transit providers. This will enable disconnected public transit districts in rural Oregon to link and provide more a connected service.

Additionally, Senate Bill 142 seeks to subject public transit entities to the oversight of Oregon Department of Transportation's transportation safety program as described in ORS Chapter 825. Currently, public transit providers are not subject to ODOT safety regulation as a specific exemption in ORS 825.017.

Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Motor Carrier Transportation Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Landscape Contractors Board
Chapter 808

Rule Caption: Clarification of required identification at examination sites.

Date:	Time:	Location:
9-1-16	9 a.m.	LCB 2111 Front St. NE, Suite 2-101 Salem, OR

Hearing Officer: Elizabeth Boxall
Stat. Auth.: ORS 670.310 & 671.670
Stats. Implemented: ORS 671.561 & 671.570
Proposed Adoptions: 808-003-0760
Last Date for Comment: 9-1-16, Close of Hearing
Summary: Clarification of required identification at examination sites.
Rules Coordinator: Kim Gladwill-Rowley
Address: Landscape Contractors Board, 2111 Front Street NE, Suite 2-101, Salem, OR 97301
Telephone: (503) 967-6291, ext. 223

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Oregon Board of Naturopathic Medicine
Chapter 850

Rule Caption: Clarifying statue with plain language in by amending 850-050-0010 and 850-050-0190.
Stat. Auth.: ORS 685.125
Stats. Implemented: ORS 685.110
Proposed Amendments: 850-050-0010, 850-050-0190
Last Date for Comment: 9-1-16, 3 p.m.
Summary: 850-050-0010 amendments include changes to (1)(a), (c), (f); and in
850-050-0190 amendments are made in (3), (5)
Text with changes is found online under Administrative rules link.
Rules Coordinator: Anne Walsh
Address: Oregon Board of Naturopathic Medicine, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0193

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Rule Caption: Addition of fee for the 2015 Legislatively mandated Health Care Workforce Database.
Stat. Auth.: ORS 685.100
Other Auth.: ORS 685.125
Stats. Implemented: ORS 685.100, 685.102
Proposed Amendments: 850-030-0035
Last Date for Comment: 9-1-16, 3 p.m.
Summary: Amendment will remove language no longer necessary in (1)(b); and add fee for Oregon Health Care Workforce Database.
Rules Coordinator: Anne Walsh
Address: Oregon Board of Naturopathic Medicine, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0193

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Rule Caption: List formulary items currently excluded from prescribing authority by Naturopathic physicians and remove unnecessary rule.
Stat. Auth.: ORS 685.125
Stats. Implemented: ORS 685.145
Proposed Adoptions: 850-060-0223
Proposed Repeals: 850-060-0225
Last Date for Comment: 9-1-16, 3 p.m.
Summary: Adds a new rule 850-060-0223 listing the formulary compendium exclusions.

Removes 850-060-0225 which is no longer relevant since all items can be found by classification in 850-060-0226.

Rules Coordinator: Anne Walsh
Address: Oregon Board of Naturopathic Medicine, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0193

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Oregon Business Development Department
Chapter 123

Rule Caption: Technical revisions to improve administrative rules for primarily standard enterprise zone exemptions.
Stat. Auth.: ORS 285A.075, 285C.060(1), 285C.066, 295C.067(2), 285C.102(3)(c), 285C.140(1) & (12), 285C.200(7) & 285C.215(3)
Stats. Implemented: ORS 285C.050–285C.250, 285C.309, 285C.400, 285C.403, 285C.500, 285C.503
Proposed Amendments: Rules in 123-674, 123-635-0150, 123-650-4500, 123-650-4800, 123-650-4900, 123-656-1600, 123-662-1000, 123-690-0500
Proposed Repeals: 123-674-1500
Last Date for Comment: 9-2-16, 5 p.m.
Summary: Proposed amendments to division 674 make a number of improvements for reading and technical/housekeeping-type purposes, respective to the standard enterprise zone property tax exemption; of particular note, the amendments will:

- Clarify and restate a number of issues related to employment, compensation and similar requirements, including as they pertain to transferring jobs into the zone and local sponsor waivers of basic requirement for 10% increase in zone employment.
- Explain how some concurrent, commonly qualified property can stop exemption after three years while other property receives full extended abatement up to five years.
- Include bulk prototype fabrication as eligible if not a function of professional service.
- Eliminate specific reference to hotel/resort zones.
- Re-specify steps of authorization approval by county assessor's office and the implications of a business firm's timely renewal (or not) of an unused authorization before the firm's property is in service and ready to begin exemption.
- Allow for transitory use of new property outside zone before its placed in service in the zone and address other intricacies of qualifying machinery & equipment (M&E).
- Fully describe elements to qualify major refurbishment, reconditioning, retrofits or upgrades of real property M&E under ORS 285C.190.
- Identify special leasing arrangements affecting an acceptable lease term.
- Comprehensive reformulation and enhancement of guidelines to deal with exemptions and grand-fathering in zones that terminate both before and programmatically in 2025.

This rulemaking also revises wording to recently amended rules in terms of:

- Timing and effect of economic data releases that determine geographic eligibility for the creation/extension of enterprise zones and for allowing business firms to use special tax benefits consistently across programs,
- Proper wording for time frame of enterprise zone determinations relative to local submissions and actions and for restrictions of hotel/resort eligibility within a zone as part of the standard enterprise zone program,
- Reservation enterprise zone tax credits, and
- Clarifying electronic commerce designation process and aligning it better with statutory language.

Rules Coordinator: Mindee Sublette
Address: Oregon Business Development Department, 775 Summer St. NE, Suite 200, Salem, OR 97301
Telephone: (503) 986-0036

Oregon Department of Aviation
Chapter 738

Rule Caption: Eliminates the ODA-issued airport license exemption for airports holding an FAA Part 139 certification.
Stat. Auth.: ORS 835.035, 835.112, 836.105
Stats. Implemented: ORS 835.015, 835.025, 836
Proposed Amendments: 738-020-0030
Last Date for Comment: 8-22-16, 8:30 a.m.
Summary: The Legislature amended ORS 836.105 by changing the fee to be paid for airport licenses and airport license renewals. Currently, OAR 738-020-0030 exempts airports holding an FAA Part 139 certification from being required to hold an airport license issued by ODA. It is the intent of the Department to align the rule with the statute and collect the corresponding airport license fees.
Rules Coordinator: Lauri Kunze
Address: Oregon Department of Aviation, 3040 25th St. SE, Salem, OR 97302-1125
Telephone: (503) 986-3171

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Oregon Department of Education
Chapter 581

Rule Caption: Healthy and Safe Facilities Plan for public schools.
Stat. Auth.: ORS 326.051, 334.125, 334.217 & 336.071
Stats. Implemented: ORS 326.051, 334.125, 334.217 & 336.071
Proposed Adoptions: 581-022-2223
Proposed Amendments: 581-024-0275
Last Date for Comment: 8-16-16, 5 p.m.
Summary: Proposed new rule and revisions to existing rule would give Department of Education authority to require school districts, public charter schools and ESDs to (1) develop a plan to ensure that recommendations from leading regulatory authorities on clean air, clean water and healthy environments are implemented to ensure our students and school district staff have a safe and healthy environment; and (2) make information available to the community.
Rules Coordinator: Cindy Hunt
Address: Oregon Department of Education, 255 Capitol St. NE, Salem, OR 97310
Telephone: (503) 947-5651

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Oregon Health Authority
Chapter 943

Rule Caption: Hospital and Ambulatory Surgery Center payment methods

Date:	Time:	Location:
8-25-16	1 p.m.	500 Summer St. NE, Rm. 137D Salem, OR 97301

Hearing Officer: Keely West
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065, 442.392
Proposed Amendments: 943-120-0350
Last Date for Comment: 8-29-16, Close of Business
Summary: The Oregon Health Authority needs to revise OAR 943-120-0350 in order to comply with ORS 442.392. Subject to SB 204 a stakeholder workgroup was convened in November 2011. The Medical Assistance program promulgated OARs to specify the methods determined by the stakeholder group but OHA neglected to promulgate a rule as well. This corrects that oversight and incorporates those methods.
Rules Coordinator: Keely L. West
Address: Oregon Health Authority, 500 Summer St. NE, E-20, Salem, OR 97301
Telephone: (503) 945-6292

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Rule Caption: General cleanup and amending Traditional Health Worker Training Certification Requirements to include Oral Health Training

Date:	Time:	Location:
8-18-16	1 p.m.	421 SW Oak St., Suite 750 Portland, OR 97204

Hearing Officer: Keely West
Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Proposed Adoptions: 410-180-0365
Proposed Amendments: 410-180-0300, 410-180-0305, 410-180-0310, 410-180-0312, 410-180-0315, 410-180-0320, 410-180-0325, 410-180-0326, 410-180-0340, 410-180-0345, 410-180-0350, 410-180-0355, 410-180-0360, 410-180-0370, 410-180-0375, 410-180-0380
Proposed Repeals: 410-180-0327
Last Date for Comment: 8-22-16, Close of Business
Summary: This rulemaking implements changes to statute made by HB 2024(2015), improves clarity of rule language and standardizes requirements for certification.
Rules Coordinator: Keely L. West
Address: Oregon Health Authority, 500 Summer St. NE, E-20, Salem, OR 97301
Telephone: (503) 945-6292

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Oregon Health Authority,
Health Systems Division: Medical Assistance Programs
Chapter 410

Rule Caption: Applications for Medical Assistance at Provider Locations and a Clarification to the Drug Copay Table

Date:	Time:	Location:
8-16-16	10:30 a.m.	500 Summer St. NE, Rm. 160 Salem, OR 97301

Hearing Officer: Sandy Cafourek
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.041, 414.025 & 414.065
Proposed Amendments: 410-120-0045, 410-120-1230
Last Date for Comment: 8-18-16, 5 p.m.
Summary: The Oregon Health Authority needs to revise OAR 410-120-0045 Applications for Medical Assistance at Provider Locations in order to reflect the new eligibility system and remove all Cover Oregon references. The Authority will also be revising OAR 410-120-1230 copayment table to clarify that the $1 copay is for non-preferred PDL generics.
Rules Coordinator: Sandy Cafourek
Address: Oregon Health Authority, Health Systems Division: Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6430

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Rule Caption: Amending Prior Authorization Approval Criteria Guide

Date:	Time:	Location:
8-16-16	10:30 a.m.	500 Summer St. NE, Rm. 160 Salem, OR 97301

Hearing Officer: Sandy Cafourek
Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.325, 414.330 to 414.414, 414.312 & 414.316
Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369, 414.371, 414.353 7 414.354
Proposed Amendments: 410-121-0040
Proposed Repeals: 410-121-0040(T)
Last Date for Comment: 8-18-16, 5 p.m.
Summary: The Pharmaceutical Services Program administrative rules (Division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

The Authority is amending this rule to update the Oregon Medicaid Fee for Service Prior Authorization Criteria Guide found at http://www.oregon.gov/oha/healthplan/Pages/pharmacy-policy.aspx based on the P&T (Pharmacy and Therapeutic) Committee recommendations.

Rules Coordinator: Sandy Cafourek
Address: Oregon Health Authority, Health Systems Division: Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6430

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Rule Caption: Amending PDL March 31, 2016 DUR/P&T Action

Date:	Time:	Location:
8-16-16	10:30 a.m.	500 Summer St. NE, Rm. 160 Salem, OR 97301

Hearing Officer: Sandy Cafourek
Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.325, 414.330 to 414.414, 414.312 & 414.316
Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369, 414.371, 414.353 & 414.354
Proposed Amendments: 410-121-0030
Proposed Repeals: 410-121-0030(T)
Last Date for Comment: 8-18-16, 5 p.m.
Summary: The Pharmaceutical Services Program administrative rules (division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

410-121-0030:
Preferred:
Epoprostenol;
Narcan® Nasal;
Injectable Naloxone.
Non-Preferred:
Calcium;
Vitamin D;
Evzio®;
Auto Injector Naloxone.

Rules Coordinator: Sandy Cafourek
Address: Oregon Health Authority, Health Systems Division: Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6430

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Oregon Health Authority,
Public Employees' Benefit Board
Chapter 101

Rule Caption: PEBB rules are being permanently amended or adopted to comply with Affordable Care Act regulations.

Date:	Time:	Location:
8-19-16	4 p.m.	PEBB/OEBB Boardroom 1225 Ferry St. SE Salem OR

Hearing Officer: Cherie Taylor
Stat. Auth.: ORS 243.061-302, 659A.060-069, 743.600–743.602 & 743.707
Stats. Implemented: ORS 243.061–243.302, 292.501 & 2007 OL Chap. 99.
Proposed Adoptions: 101-020-0059
Proposed Amendments: 101-020-0012, 101-020-0015
Last Date for Comment: 8-19-16, Close of Business
Summary: PEBB rules are being permanently amended or adopted to comply with Affordable Care Act regulations.
Rules Coordinator: Cherie Taylor
Address: Oregon Health Authority, Public Employees' Benefit Board, 1225 Ferry St. SE, Suite B, Salem, OR 97301
Telephone: (503) 378-6296

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Oregon Health Authority,
Public Health Division
Chapter 333

Rule Caption: Ambulatory Surgery Center (ASC) Circulating Nurse Requirement

Date:	Time:	Location:
8-25-16	10:30 a.m.	Portland State Office Bldg. 800 NE Oregon St., Rm. 1B Portland, OR 97232

Hearing Officer: Jana Fussell
Stat. Auth.: ORS 441.025 & 676.890
Stats. Implemented: ORS 441-015–441.065, 441.098, 442.015, 676.870–676.890, 678.362
Proposed Amendments: 333-076-0101, 333-076-0106, 333-076-0137, 333-076-0165, 333-076-0250, 333-076-0255, 333-076-0260, 333-076-0270
Last Date for Comment: 8-26-16, 5 p.m.
Summary: The Oregon Health Authority, Public Health Division is proposing to permanently amend Oregon Administrative Rules relating to circulating nurse requirements in ambulatory surgery centers (ASC) in response to concerns raised by stakeholders. In addition, minor housekeeping changes are being made.

ORS 678.362 defines and specifies requirements of a circulating nurse in a Type I ASC which the Division incorporated into administrative rule 333-076-0135 in 2006. In 2009, SB 158 (ORS 441.086) was passed classifying ASCs into three categories: 1) Certified; 2) High-complexity noncertified; and 3) Moderate complexity noncertified. In 2010, the Division amended 333-076-0135 to remove reference to a Type I ASC given no such classification existed. In February 2016, the circulating nurse provision was moved to a new rule (OAR 333-076-0137) relating to surgery services. The Division received both oral and written testimony stating that the circulating nurse requirement should not be required in ASCs performing only the practice of gastrointestinal endoscopy given that such procedures are performed in a non-sterile environment and are typically low risk. In order to ensure that the circulating nurse regulations apply to ASCs that perform higher risk procedures as intended by ORS 678.362, the Division is modifying the rule. In addition, definitions are being modified for clarification.
Rules Coordinator: Tracy Candela
Address: Oregon Health Authority, Public Health Division, 800 NE Oregon St., Suite 930, Portland, OR 97232
Telephone: (971) 673-0561

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Oregon Medical Board
Chapter 847

Rule Caption: Change the name of Consent Agreements to Consent Agreements for Re-entry to Practice
Stat. Auth.: ORS 677.235, 677.265, 677.759
Stats. Implemented: ORS 677.100, 677.110, 677.133, 677.172, 677.175, 677.190, 677.205, 677.235, 677.265, 677.270, 677.320, 677.420, 677.512, 677.759, 677.825, 677.830
Proposed Amendments: 847-001-0024, 847-001-0045, 847-008-0003, 847-020-0183, 847-050-0043, 847-070-0045, 847-080-0021
Last Date for Comment: 8-22-16, Close of Business
Summary: The proposed rule amendments memorialize the Board's decision to change the name of "Consent Agreements" to "Consent Agreements for Re-entry to Practice." The Board members voted to change the name at their April 2016 meeting in order to accurately reflect that these agreements between the Board and a licensee are used to establish a re-entry program for a licensee's return to clinical practice after two or more years. The name change is meant to eliminate any confusion that these agreements are disciplinary actions.
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: Criminal Records Checks for Employees and Volunteers

Stat. Auth.: ORS 181.534, 181A.195, 303, 676, 676.303, 677.280
Stats. Implemented: ORS 181.534, 181A.170, 181A.195, 181A.215, 676.175, 676.303, 677.280
Proposed Amendments: 847-002-0045
Proposed Repeals: 847-002-0000, 847-002-0005, 847-002-0010, 847-002-0015, 847-002-0020, 847-002-0025, 847-002-0030, 847-002-0035, 847-002-0040
Last Date for Comment: 8-22-16, Close of Business
Summary: The proposed rulemaking repeals existing procedural rules on criminal background checks of employees, volunteers, and applicants and amends one rule to refer to new statewide rules and specify the individuals subject to the rule. This rulemaking is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal records checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide 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: Reduce workforce data fee for renewing licensees and reduce supervising physician application fee for volunteers
Stat. Auth.: ORS 181A.195, 431.972, 676.410, 677.265, 677.290
Stats. Implemented: ORS 181A.195, 192.440, 431.972, 676.410, 677.265, 677.290, 677.510
Proposed Amendments: 847-005-0005
Last Date for Comment: 8-22-16, Close of Business
Summary: The proposed rule amendment reduces the one-time supervising physician application fee to $50 for physicians volunteering in free clinics or non-profit organizations, reduces the workforce data fee from $5 per licensing period to $2 per year, and corrects references to the criminal records check statutes, which were recently renumbered.
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: Grammatical correction to reactivation requirements rule
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.172, 677.190, 677.265, 677.512, 677.759, 677.825, 677.830
Proposed Amendments: 847-008-0055
Last Date for Comment: 8-22-16, Close of Business
Summary: The proposed rule amendment corrects the grammatical structure of the sentence regarding the additional items the Board may require of a licensee applying for reactivation; there are no substantive 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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Rule Caption: Criminal Records Checks for Applicants and Licensees
Stat. Auth.: ORS 181A.195, 181A.215, 676.303, 677.265
Stats. Implemented: ORS 181.534, 181A.170, 181A.195, 181A.215, 670.280, 676.330, 677.100, 677.265
Proposed Amendments: 847-008-0068
Last Date for Comment: 8-22-16, Close of Business
Summary: The proposed rule amendment references new statewide rules on criminal records checks recently adopted by the Department of Administrative Services (DAS) and includes language specific to the Oregon Medical Board that is consistent with ORS chapter 181A and the DAS rules. The rule specifies that applicants and licensees are subject to a criminal records check under this rule, refers to statewide rules on criminal records checks, provides the appeals process, and maintains the fee charged to the individual. This rulemaking is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave DAS authority to adopt statewide administrative rules for criminal records checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide 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: Exam and document requirements for license applications
Stat. Auth.: ORS 181A.195, 677.100, 677.133, 677.265, 677.759, 677.820
Stats. Implemented: ORS 181A.195, 677.100, 677.120, 677.133, 677.190, 677.265, 677.512, 677.759, 677.820, 677.825, 677.830
Proposed Amendments: 847-020-0150, 847-023-0010, 847-026-0015, 847-050-0025, 847-070-0019, 847-080-0013
Last Date for Comment: 8-22-16, Close of Business
Summary: The proposed rule amendments remove references to the DEA exam. The prescription drug questions of highest importance have been incorporated into the new MPA exam. The rules also clearly state the attempt limitations on the open-book examination. The rule related to documents to be submitted in the Expedited Endorsement process has been updated and streamlined in keeping with other rule divisions and to allow for electronic fingerprint submission through the new Fieldprint program.
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: Define Oriental massage within the acupuncture scope of practice
Stat. Auth.: ORS 677.265, 677.759
Stats. Implemented: ORS 677.265, 677.757, 677.759, 677.780
Proposed Amendments: 847-070-0005
Last Date for Comment: 8-22-16, Close of Business
Summary: The proposed rule amendment adds a definition for Oriental massage and clarifies the definition for physician.
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: Sets forth agency rule for pursuing legal remedies in cases of fraud.

Date:	Time:	Location:
8-23-16	2 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: 459-005-0260
Last Date for Comment: 9-2-16, 5 p.m.
Summary: The purpose of this new rule is to emphasize that the PERS Board will actively pursue all available legal remedies in cases of fraud. These legal remedies include but are not limited to: working with the Oregon Attorney General's office in bringing civil actions under ORS 180.755 against individuals who have committed any number of enumerated prohibited acts against PERS, such as presenting for payment or approval, or cause to be presented for

payment or approval, a claim that the individual knows is a false claim; also, working with the appropriate district attorney's office in bringing criminal charges against individuals who have defrauded or attempted to defraud PERS by committing criminal acts of perjury, mail theft, forgery, and/or identity theft as these crimes are defined under Chapters 162, 164 and 165 of the Oregon Revised Statutes.
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: Clarifies division of top prize when won by multiple tickets in single drawing; housekeeping edits

Date:	Time:	Location:
8-18-16	2 p.m.	Oregon State Lottery Headquarters 500 Airport Rd. SE Salem, Oregon 97301

Hearing Officer: Staff
Stat. Auth.: ORS Chapter 461
Other Auth.: Oregon Constitution, Article XV, Section 4(4)
Stats. Implemented: ORS 461.210, 461.220, 461.230, 461.240 & 461.250
Proposed Amendments: 177-094-0080
Last Date for Comment: 8-18-16, 2:30 p.m.
Summary: The Oregon Lottery has initiated temporary and permanent rulemaking to amend the above referenced administrative rule to clarify the process when the Win for Life top prize is won by multiple ticket holders in a single drawing and the prize cannot be divided evenly among the winners.

Other edits are housekeeping changes to amend cross references.
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 State Marine Board
Chapter 250

Rule Caption: Authorization to operate a boat at Willamette Falls in accordance with the Ceremonial Harvest Permit

Date:	Time:	Location:
8-24-16	7 p.m.	Oregon State Marine Board 435 Commercial St. NE Suite 400 Boardroom Salem, OR 97301

Hearing Officer: Glenn Dolphin
Stat. Auth.: ORS 830.110, 830.175
Stats. Implemented: ORS 830.175
Proposed Amendments: 250-020-0032
Last Date for Comment: 9-16-16, 5 p.m.
Summary: This rule will allow the Confederated Tribes of the Grand Ronde to operate a boat in the area of the Oregon City Falls on the Willamette River to construct and access a fishing platform. Housekeeping and technical corrections to the regulations may occur to ensure rule consistency.
Rules Coordinator: June LeTarte
Address: Oregon State Marine Board, P.O. Box 14145, Salem, OR 97309-5065
Telephone: (503) 378-2617

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Rule Caption: This rule action will establish a two year biennial Charter boat license fee.

Date:	Time:	Location:
9-7-16	7 p.m.	OR Coast Community College Rm. 140 400 SE College Way Newport, OR 97366
9-13-16	7 p.m.	Curry County Sheriff Office EOC Rm. 29808 Colvin St. Gold Beach, OR 97444

Hearing Officer: Mervin Hee
Stat. Auth.: ORS 830.437
Stats. Implemented: ORS 830.437
Proposed Amendments: 250-015-0005
Last Date for Comment: 9-16-16, 5 p.m.
Summary: This rule action will establish a two year biennial Charter Boat license fee.
Rules Coordinator: June LeTarte
Address: Oregon State Marine Board, P.O. Box 14145, Salem, OR 97309-5065
Telephone: (503) 378-2617

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Rule Caption: Authorization for agency representative to appear on behalf of agency at particular classes of hearings.
Stat. Auth.: ORS 830.110, 183.452
Stats. Implemented: ORS 704.040, 830.465, 830.420, 830.815
Proposed Adoptions: 250-001-0035
Last Date for Comment: 8-31-16, 5 p.m.
Summary: This rule confirms that a Marine Board employee may represent the agency in a particular class of contested case hearings: outfitter and guide registrations and civil penalties; charter/livery registrations and certificates; and registrations and certificates in accordance with ORS 183.452. Housekeeping and technical corrections to the regulations may occur to ensure rule consistency.
Rules Coordinator: June LeTarte
Address: Oregon State Marine Board, P.O. Box 14145, Salem, OR 97309-5065
Telephone: (503) 378-2617

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Parks and Recreation Department
Chapter 736

Rule Caption: Establishes procedures and criteria for the Oregon Main Street Revitalization Grant program

Date:	Time:	Location:
8-16-16	11 a.m.	North Mall Office Bldg. 725 Summer St., Rm. 124B, Salem OR

Hearing Officer: Staff
Stat. Auth.: ORS 390.262, 390.264
Stats. Implemented: ORS 390.262, 390.264
Proposed Adoptions: 736-056-0000, 736-056-0010, 736-056-0020, 736-056-0030, 736-056-0040, 736-056-0050, 736-056-0060, 736-056-0070, 736-056-0080
Last Date for Comment: 8-19-16, 5 p.m.
Summary: These administrative rules establish procedures and criteria that the Oregon Parks and Recreation Department will use to administer the Oregon Main Street Revitalization Grant Program authorized in ORS 390.262 and ORS 390.264
Rules Coordinator: Claudia Ciobanu
Address: Parks and Recreation Department, 725 Summer St. NE, Suite C, Salem, OR 97301-1226
Telephone: (503) 872-5295

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Public Utility Commission
Chapter 860

Rule Caption: Reporting Rules for Companies with a Qualified Project Determination from the Public Utility Commission

Date:	Time:	Location:
8-16-16	1:30 p.m.	Public Utility Commission 201 High St. SE, Hearing Rm. Salem, OR 97301

Hearing Officer: Ruth Harper
Stat. Auth.: ORS 308.681, 756.040, 756.060
Stats. Implemented: ORS 308.681

Proposed Adoptions: 860-200-0200, 860-200-0250
Last Date for Comment: 9-9-16, 5 p.m.
Summary: The proposed rules will enable the Public Utility Commission to implement ORS 308.681(2) which requires the Commission to submit a report each year to the Legislative Assembly regarding each company whose property is granted a property tax exemption under ORS 308.677. The Commission cannot make this report without first gathering information from the companies that may be granted any exemption under ORS 308.677. The proposed rules establish an annual reporting requirement for a company that has received a qualified project determination from the Commission under ORS 308.677, which is a prerequisite for the tax exemption.

The Commission encourages participants to file written comments as early as practicable in the proceedings so that other participants have the opportunity to consider and respond to the comments before the deadline. Please reference Docket No. AR 597 on comments and file them by e-mail to the Commission's Filing Center at PUC.FilingCenter@state.or.us.

Interested persons may review all filings online at http://apps.puc.state.or.us/edockets/docket.asp?DocketID=20055. For guidelines on filing and participation, please see OAR 860-001-0140 through 860-001-0160 and 860-001-0200 through 860-001-0250 found online at http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_860/860_001.html.

Participants wishing to monitor the hearing by telephone must contact Diane Davis at diane.davis@state.or.us or (503) 378-4372 by close of business August 12, 2016, to request a dial -in number. The Commission strongly encourages those planning to present oral comment at the hearing to attend in person.
Rules Coordinator: Diane Davis
Address: Public Utility Commission of Oregon, PO Box 1088, Salem, OR 97308-1088
Telephone: (503) 378-4372

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Rule Caption: In the Matter of Rulemaking to Prescribe Application Requirements for Transportation Electrification Programs.

Date:	**Time:**	**Location:**
8-22-16	9:30 a.m.	Public Utility Commission 201 High St. SE, Hearing Rm. Salem, OR 97301

Hearing Officer: ALJ Ruth Harper
Stat. Auth.: ORS 756.040, 756.060, OL 2016 Ch. 028, Sec.. 20 (SB 1547)
Stats. Implemented: OL 2016 Ch. 028, Sec. 20 (SB 1547)
Proposed Adoptions: 860-087-0001, 860-087-0010, 860-087-0020, 860-087-0030, 860-087-0040
Last Date for Comment: 9-9-16, 5 p.m.
Summary: This rulemaking implements Oregon Laws 2016, chapter 028, section 20, which requires the Public Utility Commission of Oregon (PUC) to prescribe the form and manner of applications for programs to accelerate transportation electrification. The electric companies subject to this rule must file applications for programs to accelerate transportation electrification on or before December 31, 2016. The proposed rules list the information that an electric company must provide in a transportation electrification program application and plan and clarify filing deadlines.

The Commission encourages participants to file written comments as early as practicable in the proceedings so that other participants have the opportunity to consider and respond to the comments before the deadline. Please reference Docket No. AR 599 on comments and file them by e-mail to the Commission's Filing Center at PUC.FilingCenter@state.or.us.

Interested persons may review all filings online at http://apps.puc.state.or.us/edockets/docket.asp?DocketID=20129. For guidelines on filing and participation, please see OAR 860-001-0140 through 860-001-0160 and 860-001-0200 through 860-001-0250 found online at http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_860/860_001.html.

Participants wishing to monitor the hearing by telephone must contact Diane Davis at diane.davis@state.or.us or (503) 378-4372 by close of business August 19, 2016, to request a dial-in number. The Commission strongly encourages those planning to present oral comment at the hearing to attend in person.
Rules Coordinator: Diane Davis
Address: Public Utility Commission of Oregon, PO Box 1088, Salem, OR 97308-1088
Telephone: (503) 378-4372

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Southern Oregon University
Chapter 573

Rule Caption: Repeal 573-076 Code of Conduct Administrative Rule
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-076-0000, 573-076-0010, 573-076-0020, 573-076-0030, 573-076-0040, 573-076-0050, 573-076-0060, 573-076-0070, 573-076-0080, 573-076-0090, 573-076-0100, 573-076-0110, 573-076-0120, 573-076-0130
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rule 573-076. This rule will be adopted as a University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal 573-005 Faculty Grievance Procedures
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-005-0005, 573-005-0015, 573-005-0025, 573-005-0035, 573-005-0045, 573-005-0055, 573-005-0065, 573-005-0075, 573-005-0085, 573-005-0095, 573-005-0105, 573-005-0115, 573-005-0125, 573-005-0135, 537-005-0145, 573-005-0155, 573-005-0165, 573-005-0175, 573-005-0185, 573-005-0195, 573-005-0205, 573-005-0215
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rule 573-005. This rule will be adopted as a University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal 573-010 Faculty Records Policy
Stat. Auth.: ORS 351-070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-010-0005, 573-010-0010, 573-010-0015, 573-010-0020, 573-010-0025, 573-010-0030, 573-010-0035, 573-010-0040, 573-010-0045, 573-010-0050, 575-010-0055, 573-010-0060, 573-010-0065, 573-010-0070
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rule 573-010. This rule will be adopted as a University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

Rule Caption: Repeal 573-015 and 573-025 Administrative Rules
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-015-0005, 573-015-0010, 573-025-0005
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rules 573-015 and 573-025. These rules will be adopted as University Policies as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal of 573-026 Medical Insurance
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-026-0005
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rule 573-026. This rule will be adopted as University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal of 573-030 Model Rules of Procedure Applicable to Contested Cases
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-030-0005, 573-030-0015, 573-030-0025, 573-030-0026, 573-030-0030, 573-030-0035, 573-030-0040, 573-030-0045, 573-030-0050, 573-030-0051, 573-030-0052, 573-030-0053, 573-030-0055, 573-030-0060, 573-030-0065
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rule 573-030. This rule will be adopted as University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal 573-035 Discrimination
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-035-0005, 573-035-0010, 573-035-0020, 573-035-0030, 573-035-0040, 573-035-0050, 573-035-0060, 573-035-0070, 573-035-0080
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rule 573-035. This rule will be adopted as University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal 573-040, 573-042, and 573-045 Administrative Rules
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-040-0005, 573-042-0005, 573-045-0000, 573-045-0005, 573-045-0010, 573-045-0020
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rules 573-040, 573-042, and 573-045. These rules will be adopted as University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal 573-051 and 573-055
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-051-0005, 573-051-0010, 573-051-0020, 573-051-0030, 573-051-0040, 573-051-0050, 573-055-0010, 573-055-0020, 573-055-0030, 573-055-0040, 573-055-0050
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rules 573-051 and 573-055. These rules will be adopted as University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal 573-070 and 573-071 Administrative Rules
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-070-0001, 573-070-0004, 573-070-0005, 573-070-0011, 573-070-0012, 573-070-0013, 573-070-0067, 573-070-0068, 573-071-0005, 573-071-0010, 573-071-0020, 573-071-0040
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rules 573-070 and 573-071. These rules will be adopted as University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Rule Caption: Repeal 573-075, 573-080, and 573-095
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Repeals: 573-075-0120, 573-075-0200, 573-075-0230, 573-075-0240, 573-075-0250, 573-075-0260, 573-080-0005, 573-080-0025, 573-095-0000, 573-095-0005, 573-095-0010
Last Date for Comment: 8-30-16, 12 p.m.
Summary: Southern Oregon University is repealing Administrative Rules 573-075, 573-080, and 573-095. These rules will be adopted as University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague
Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
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Rule Caption: Repeal 573-001 Procedural Rules
Stat. Auth.: 351.070
Stats. Implemented: 351.070
Proposed Repeals: 573-001-0000, 573-001-0010, 573-001-0020, 573-001-0030, 573-001-0040, 573-001-0050, 573-001-0055, 573-001-0060, 573-001-0070, 573-001-0075
Last Date for Comment: 08-30-2016 12:00 p.m.
Summary: Southern Oregon University is repealing Administrative Rule 573-001,. This rule will be adopted as University Policy as of September 1, 2016.
Rules Coordinator: Treasa Sprague

Address: Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
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Teacher Standards and Practices Commission
Chapter 584

Rule Caption: Adopts, amends and repeals rules related to educator licensure and approval of preparation programs.
Stat. Auth.: ORS 342
Stats. Implemented: OL 2015, ch 756 (SB 78); OL 2015 ch 279 (SB 83); OL 2015 ch 245 (HB 2412) and OL 2015, ch 647 (HB 2411).; ORS 342.120–342.430, 342.455–342.495 & 342.553
Proposed Adoptions: Division 10: 584-010-0004, 584-010-0125, Division 17: 584-017-1037
Proposed Amendments: Division 17: 584-017-1100, Division 20: 584-020-0060, Division 70: 584-070-0111, 584-070-0012 , Division 200: 584-200-0005, 584-200-0030, Division 210: 584-210-0030, 584-210-0040, 584-210-0050, 584-210-0060, 584-210-0070, 584-210-0100, 584-210-0160, Division 220: 584-220-0010, 584-220-0080, 584-220-0110, 584-220-0215, 584-220-0220, 584-220-0225, Division 225: 584-225-0050, 584-225-0060, Division 420: 584-420-0010, 584-420-0310, 584-420-0360, 584-420-0365, 584-420-0420, 584-420-0425, 584-420-0490, 584-420-0630
Proposed Repeals: Division 50: 584-050-0060; 584-050-0065; 584-050-0066; 584-050-0070 Division 420: 584-420-0300; 584-420-0375; 584-420-0390
Proposed Ren. & Amends: Division 50: 584-020-0060 to 584-050-0125
Last Date for Comment: 10-15-16, 5 p.m.
Summary: 584-020-0060 clarifies process for termination of informal reproval process and renumbers to 584-050-0060 so it will be with other professional practices rules.

584-050-0060; 584-050-0065; 584-050-0066; 584-050-0067; 584-050-0070: Repeals rules because the underlying statutory language was repealed in Or Laws 2015 ch 245 (HB 2412)).

584-010-0004 Adopts provisions to provide guidance to programs for state approval process during transition to national accreditation requirements pursuant to Or Laws 2015, ch 756 (SB 78) .

584-010-0125 Adopts a method to allow programs to create innovative and collaborative programs on an experimental basis.

584-017-0110 Clarifies that the edTPA assessments must be submitted for national scoring for 16-17 school year. Clarifies that candidates adding endorsements to existing licenses in a program-required area must still complete a work sample or edTPA (national scored or local evaluation).

584-017-0137 Adopts program standards for cooperating teachers pursuant to Or Laws 2015 ch 279 (SB 83).

584-070-0111 Changes name of license from Transitional to Reciprocal. Clarifies process for moving to Preliminary license.

584-200-0005 Permits applicants who previously held middle level endorsement to add foundational endorsements with only a test. Provides a 120 day grace period to all licenses that expire on June 30, 2016.including restricted sub licenses.

584-200-0030 Defines a month as 30 days for purposes of late fees. Adds provision to allow 30 days to reopen an application after issuing license if new information is received.

584-210-0030 Clarifies that recency requirements do not apply to applicants moving directly from a Reciprocal to a Preliminary.

584-210-0040 Clarifies the applicant must hold an Initial, Initial I, Initial II, reciprocal, preliminary teaching license or equivalent out-of-state license to count teaching experience for Professional license. Permits .5 to .99 teaching experience for six years to meet experience requirement for the Professional.

584-210-0050 Creates more flexible provisions related to teaching experience and evaluations for Teacher Leader license.

584-210-0060 Allows certain applicants who have previously held restricted licenses to apply for Reciprocal license.

584-210-0070 Removes provision that allows out-of-state people to be issued the legacy.

584-210-0100 Clarifies that an applicant may hold an emergency, charter school and restricted substitute license prior to qualifying restricted teaching license.

584-210-0160 Removes provisions related to highly qualified.

584-220-0010 Changes name from Family and Consumer Studies to Family and Consumer Sciences

584-220-0080 Changes name from Family and Consumer Studies to Family and Consumer Sciences

584-420-0010 Clarifies ELL standards apply to all candidates in all programs

Division 220: 584-220-0215; 584-220-0220; 584-220-0225; 584-420-0490: Clarifies requirements for language proficiency.

Division 225: 584-225-0050; 584-225-0060; 584-420-0630. Clarifies language proficiency requirements.

Division 420: 584-420-0310; 584-420-0360; 584-420-0365; 584-420-0415; 584-420-0420; 584-420-0425; 584-420-0475; 584-420-0490 Clarifies that work samples or edTPA (locally or nationally scored) are required for advanced candidates completing the program-required areas to add an endorsement.

584-420-0300; 584-420-0375; 584-420-0390 Repeals single subject endorsement area program standards: Advanced Mathematics Endorsement: Program Standards; Foundational Math Endorsement: Program Standards; Health: Program Standards

Makes other housekeeping changes.

The agency is seeking public comment on the proposed rules, including advantages, disadvantages, alternative options, and potential costs of implementing. Please submit written comments to TSPC.RuleTestimony@state.or.us by October 15, 2016 (5:00 pm).
Rules Coordinator: Tamara Dykeman
Address: Teacher Standards and Practices Commission, 250 Division St. NE, Salem, OR 97301
Telephone: (503) 378-3586

Board of Accountancy
Chapter 801

Rule Caption: Amend to update the effective date of professional standards adopted by the Board
Adm. Order No.: BOA 1-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-28-16
Notice Publication Date: 6-1-2016
Rules Amended: 801-001-0035
Subject: The professional standards as used throughout OAR Chapter 801 are those that are in effect as of January 1, 2016
Rules Coordinator: Kimberly Fast—(503) 378-2268

801-001-0035
Professional Standards

The professional standards, interpretations, rulings and rules designated and adopted by the Board in OAR Chapter 801 are those in effect as of January 1, 2016.

Stat. Auth.: ORS 183.332 & 673.410
Stats. Implemented: ORS 183.337 & 673.410
Hist.: BOA 2-2003, f. 12-23-03 cert. ef. 1-1-04; BOA 2-2005, f. 2-24-05 cert. ef. 3-1-05; BOA 5-2005, f. 11-22-05, cert. ef. 1-1-06; BOA 1-2006, f. 12-22-06, cert. ef. 1-1-07; BOA 1-2007, f. 12-27-07 cert. ef. 1-1-08; BOA 1-2008, f. 12-30-08, cert. ef. 1-1-09; BOA 1-2009, f. 12-15-09 cert. ef. 1-1-2010; BOA 1-2010, f. 12-15-10, cert. ef. 1-1-11; BOA 1-2011, f. 12-28-11, cert. ef. 1-1-12; BOA 1-2013, f. & cert. ef. 1-8-13; BOA 1-2014, f. 2-14-14, cert. ef. 3-1-14; BOA 2-2014, f. 12-15-14, cert. ef. 1-8-15; BOA 2-2015(Temp), f. 12-30-15, cert. ef. 1-1-16 thru 6-28-16; BOA 1-2016, f. & cert. ef. 6-28-16

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Board of Nursing
Chapter 851

Rule Caption: Add Endorsement application fee of $9 to existing fees per SB 1585
Adm. Order No.: BN 3-2016
Filed with Sec. of State: 7-13-2016
Certified to be Effective: 8-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 851-002-0010
Subject: SB 1585 added the $9 surcharge to fund the Oregon Nursing Advancement Fund to now include applications for Endorsement, in addition to new and renewal applications.
Rules Coordinator: Peggy A. Lightfoot—(971) 673-0638

851-002-0010
RN/LPN Schedule of Fees

(1) License Renewal — $145.
(2) Delinquent fee — $100.
(3) Surcharge to Support the Workforce Data Analysis Fund at Renewal — $5.
(4) Surcharge to Support the Oregon Nursing Advancement Fund for Licensure by Examination, Licensure by Endorsement, and Renewal applications — $9.
(5) License by Endorsement — $195.
(6) Licensure by Examination — $160.
(7) Written Verification of License — $12.
(8) Limited Licenses:
(a) Reentry — $95.
(b) Extension of Reentry — $25.
(9) Limited Licenses for Educational Experience:
(a) International Graduate Nursing Students — $65.
(b) Extension of International Graduate Nursing Students — $25.
(c) International RN in Short-Term Educational Experience — $35.
(d) International Exchange Students — $25.
(e) U.S. RNs in Distance Learning — $15.
(f) Extension of Distance Learning — $15.
(10) Reexamination for Licensure — $25.
(11) Reactivation — $160.
(12) Reinstatement by Reactivation — $160.
(13) Nurse Emeritus — $50 (biennial)

Stat. Auth.: ORS 678.150 & 678.410
Stats. Implemented: ORS 678.410
Hist.: NER 26(Temp), f. & ef. 12-11-75; NER 32, f. & ef. 5-4-76; NER 5-1981, f. & ef. 11-24-81; NER 2-1982, f. & ef. 8-25-82; NER 5-1983, f. 12-9-83, ef. 1-1-84; NER 5-1985, f. 7-30-85, ef. 10-1-85; NER 6-1986, f. & ef. 12-3-86; NB 5-1987, f. & ef. 7-1-87; NB 7-1987, f. & ef. 10-5-87; NB 1-1988, f. & cert. ef. 4-18-88; NB 2-1989, f. 6-22-89, cert. ef. 7-1-89; NB 2-1991, f. 6-14-91, cert. ef. 7-1-91; NB 3-1991, f. & cert. ef. 9-25-91; NB 5-1993, f. 6-15-93, cert. ef. 7-1-93; NB 7-1993, f. & cert. ef. 7-1-93; NB 13-1993, f. & cert. ef. 12-20-93; NB 5-1994 f. & cert. ef. 9-15-94; Renumbered from 851-020-0295; NB 8-1994, f. & cert. ef. 12-7-94; NB 7-1995(Temp), f. & cert. ef. 6-23-95; NB 2-1996, f. & cert. ef. 3-12-96; NB 9-1997, f. 7-22-97, cert. ef. 9-1-97; BN 6-1998(Temp), f. & cert. ef. 7-15-98 thru 12-31-98; Administrative correction 8-5-98; BN 10-1998, f. & cert. ef. 8-7-98; BN 11-1998, f. & cert. ef. 9-22-98; BN 4-1999, f. 5-21-99, cert. ef. 7-1-99, Renumbered from 851-031-0200; BN 11-1999, f. & cert. ef. 12-1-99; BN 6-2000, f. & cert. ef. 4-24-00; BN 17-2002, f. & cert. ef. 10-18-02; BN 6-2003, f. & cert. ef. 7-7-03; BN 5-2007, f. 5-4-07, cert. ef. 7-1-07; BN 5-2009, f. & cert. ef. 10-7-09; BN 6-2009, f. 12-17-09, cert. ef. 1-1-10; BN 7-2010, f. & cert. ef. 6-25-10; BN 16-2010, f. & cert. ef. 11-29-10; BN 10-2012, f. 7-6-12, cert. ef. 8-1-12; BN 1-2015, f. 4-21-15, cert. ef. 6-1-15; BN 3-2015, f. 9-22-15, cert. ef. 10-1-15; BN 4-2015, f. & cert. ef. 10-29-15; BN 3-2016, f. 7-13-16, cert. ef. 8-1-16

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Rule Caption: Revise division to include Alternative to Discipline and Public Discipline monitoring programs.
Adm. Order No.: BN 4-2016
Filed with Sec. of State: 7-15-2016
Certified to be Effective: 8-1-16
Notice Publication Date: 6-1-2016
Rules Adopted: 851-070-0025, 851-070-0045, 851-070-0075
Rules Amended: 851-070-0000, 851-070-0005, 851-070-0010, 851-070-0020, 851-070-0030, 851-070-0040, 851-070-0050, 851-070-0060, 851-070-0070, 851-070-0080, 851-070-0090, 851-070-0100
Subject: To clarify the requirements and expectations for entering, complying, and successful completion of the Board's alternative to discipline program and the public discipline board orders.
Rules Coordinator: Peggy A. Lightfoot—(971) 673-0638

851-070-0000
Purpose, Intent and Scope

The Board believes that licensees who develop substance use disorders, mental disorders, or both disorders can, with appropriate treatment, be assisted with recovery and return to the practice of nursing with appropriate workplace monitoring. In assuring public protection, it is the intent of the Board that a licensee with a substance use disorder, a mental disorder or both types of disorders may have the opportunity to enter the Alternative to Discipline (ATD), known in Oregon as the Health Professionals' Services Program (HPSP) as a Board referral or a self-referral. Based upon review of each individual circumstance, the Board may, instead of allowing entry into HPSP, order public discipline. Substantial non-compliance with the requirements of the ATD or public discipline program may lead to further disciplinary action by the Board. For Licensees with Cognitive or Physical Impairment without associated Behavioral Health Diagnosis return to work monitoring will be done through public discipline and are not eligible for the ATD program.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0005
Definitions

The following definitions apply to OAR chapter 851, division 070, except as otherwise stated in the definition:

(1) "Abstinence" means the avoidance of all intoxicating substances, including but not limited to prescription or over-the-counter drugs with a potential for abuse or the potential to develop a substance use disorder. Despite marijuana (either recreational or medical) and alcohol being legal, monitoring programs prohibit use of either substance. This definition does not include medically appropriate prescriptions.

(2) "Alternative to Discipline (ATD)" means that in the state of Oregon, the Alternative to Discipline program is known as the Health Professionals Services Program and is administered by the Oregon Health Authority, Addictions and Mental Health Division.

(3) "Assessment or evaluation" means the process an independent third-party evaluator uses to diagnose the licensee and to recommend treatment options for the licensee.

(4) "Authorized Prescription" means a prescription for medically appropriate medications obtained by the licensee from a prescriber authorized to prescribe by the statute and rules of the prescriber's specific regulatory Board.

(5) "Behavioral Health" is inclusive of substance use disorders, mental disorders, or combination of disorders as defined in DSM.

(6) "Board" means the Oregon State Board of Nursing.

(7) "Business day" means Monday through Friday, except legal holidays as defined in ORS 187.010 or 187.020.

(8) "Certificate Holder" means a Certified Nursing Assistant, Certified Medication Aide.

(9) Cognitive Impairment means an individual having trouble remembering, learning new things, concentrating or making decisions that affect their ability to practice nursing.

(10) "Diagnosis" means the principal mental health or substance use diagnosis listed in the Diagnostic and Statistical Manual (DSM). The diagnosis is determined through an assessment and any examinations, tests or consultations suggested by the assessment, and is the medically appropriate reason for services.

(11) "Division" means the Oregon Health Authority, Addictions and Mental Health Division.

(12) "DSM" means the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(13) "Federal regulations" means:

(a) As used in ORS 676.190(1)(f)(D), a "positive toxicology test result as determined by federal regulations pertaining to drug testing" means test results meeting or exceeding the cutoff concentrations shown in 49 CFR § 40.87 (2011) must be reported as substantial non-compliance, but positive toxicology results for other drugs and for alcohol may also constitute, and may be reported as, substantial non-compliance.

(b) As used in ORS 676.190(4)(i), requiring a "licensee to submit to random drug or alcohol testing in accordance with federal regulations" means licensees are selected for random testing by a scientifically valid method, such as a random number table or a computer-based random number generator that is matched with licensees' unique identification numbers or other comparable identifying numbers. Under the selection process used, each covered licensee shall have an equal chance of being tested each time selections are made, as described in 40 CFR § 199.105(c)(5) (2011). Random drug tests must be unannounced and the dates for administering random tests must be spread reasonably throughout the calendar year, as described in 40 CFR § 199.105(c)(7) (2011).

(14) "Fitness to practice evaluation" means the process a qualified evaluator uses to determine if the licensee can safely perform the essential functions of the licensee's health practice. Fitness to Practice evaluation may be in addition to a Treatment Program Evaluation.

(15) "Final enrollment" means the licensee has provided all documentation required by OAR 851-070-0040 and has met all eligibility requirements to participate in the ATD.

(16) "Final Board Order" means the document describing the terms and conditions of the public discipline.

(17) "Impaired Professional" as defined in ORS 676.303, means a licensee who is unable to practice with professional skill and safety by reason of habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability or by reason of a mental disorder.

(18) "Independent third-party evaluator" means an individual who is approved by a licensee's Board to evaluate, diagnose, and offer treatment options for substance use disorders, mental disorders, or co-occurring disorders.

(19) "Individual monitoring/compliance record" means the official permanent documentation, written or electronic, for each licensee, which contains all information required by these rules and maintained to demonstrate compliance with these rules.

(20) "Interim Consent Order (ICO)" means an agreement in which a licensee voluntarily steps away from practice until further order of the Board.

(21) "Licensee" means a licensed practical nurse, registered nurse, or advanced practice registered nurse who is licensed or certified by the Oregon State Board of Nursing.

(22) "Mental disorder" means a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom that is identified in the DSM. "Mental disorder" includes gambling disorders.

(23) "Monitoring agreement" means an individualized agreement between a licensee and the vendor that meets the requirements for a non-disciplinary agreement set by ORS 676.190.

(24) "Monitored Practice" means practice under the direct supervision of a worksite monitor by agreement or Board order. The ability to provide monitored practice is determined by the employer.

(25) "Non-treatment compliance monitoring" means the non-medical, non-therapeutic services employed to track and report the licensee's compliance with the monitoring agreement or Board order.

(26) "Nurse Monitoring Program" (NMP) means the alternative to the Board of Nursing's discipline program prior to July 1, 2010.

(27) Physical Impairment means the ability to move, coordinate actions, or perform physical activities is significantly limited or delayed and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement, performing daily life functions.

(28) "Provisional enrollment" means temporary enrollment, pending verification that a self-referred licensee meets all ATD eligibility criteria.

(29) "Public Discipline" means action against a licensee or certificate holder resulting in public reporting of the discipline, including posting on the OSBN website and in the OSBN publications. Public Discipline is a permanent document that remains publicly displayed for the life of the license/certificate even after all requirements of the public discipline are satisfied. For the impaired nurse public discipline usually takes the form of probation (which includes monitored practice), although the Board can levy discipline up to and including revocation. For this rule, Public Discipline will be referred to as "Probation."

(30) "Self-referred licensee" means an eligible licensee who entered participation in the HPSP program without a referral from the board.

(31) "Stipulated Agreement" means the document describing the terms and conditions of public discipline agreed to by the licensee and approved by Board order.

(32) "Substance use disorder" means a disorder related to the taking of a drug of abuse (including alcohol); to the side effects of a medication; and to a toxin exposure, including: substance use disorders (substance dependence and substance abuse) and substance-induced disorders (including but not limited to substance intoxication, withdrawal, delirium, and dementia, as well as substance induced psychotic disorders and mood disorders), as defined in DSM criteria.

(33) "Substantial non-compliance" means that a licensee is in violation of the terms of his or her monitoring agreement or Board Order in a way that gives rise to concerns about the licensee's ability or willingness to participate in the HPSP or is in violation of the Board Order. Substantial non-compliance and non-compliance include, but are not limited to, the factors listed in ORS 676.190(1)(f). Conduct that occurred before a licensee entered into a monitoring agreement does not violate the terms of that monitoring agreement, notwithstanding a complaint to the Board regarding conduct related to the reason for entering the monitoring agreement/Stipulated Order.

(34) "Successful completion" means that for the period of service deemed necessary by the vendor or by the Board by rule, the licensee has satisfactorily complied with the licensee's monitoring agreement or Board order.

(35) "Toxicology testing" means urine testing or alternative chemical monitoring including blood, saliva, breath, or hair as conducted by a laboratory certified, accredited or licensed and approved for toxicology testing.

(36) "Treatment" means the planned, specific, individualized health and behavioral health procedures, activities, services and supports that a treatment provider uses to remediate symptoms of a substance use disorder, mental disorder or both types of disorders.

(37) "Vendor" means the entity that has contracted with the Division to conduct the ATD.

(38) "Worksite Monitor" means a licensed health professional or appropriate individual approved by the Board designated to:

(a) Conduct routine observation/monitoring of licensee's performance.

(b) To make / contribute to verbal and written reports.

(c) To intervene when patient and/or public safety is at risk.

(d) To intervene, in the case of the licensee/certificate holder who does not directly care for patients, when there is indication of impairment in the workplace.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 2-2013, f. 2-28-13, cert. ef. 4-1-13; BN 1-2014, f. 3-3-14, cert. ef. 4-1-14; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0010
Participation in Health Professionals' Services Program

The Oregon State Board of Nursing's ATD is the HPSP program. (For the purposes of this rule, from here on, the ATD program will be referred to as the HPSP). Effective July 1, 2010, the Board shall participate in the Health Professionals' Services Program and may refer eligible nurses to the HPSP in lieu of or in addition to public discipline. Only licensed practical nurses, registered nurses, and advanced practice registered nurses who meet the eligibility criteria may be referred by the Board to HPSP.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200

Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0020
Eligibility for enrollment in Health Professionals' Services Program (HPSP)

(1) Licensee must be evaluated by an independent, third-party evaluator approved by the Board. The evaluation must include a diagnosis of a substance use disorder, mental disorder, or both types of disorders with the appropriate diagnostic code from the DSM, and treatment options. The evaluation must also include return to work conditions. If not included in the initial treatment evaluation, the licensee will need to obtain a second evaluation to identify specific return to work recommendations or this may be determined by qualified Board staff.

(2) Must have reasonable ability to meet the monitored practice requirement.

(3) Licensees who have successfully completed either the NMP or HPSP programs and who have had a reoccurrence of impairment may be permitted a maximum of one additional admittance into the HPSP upon Board approval.

(4) If eligibility for HPSP is met, the Board will make the final determination if the licensee may be referred to HPSP or be placed on public discipline.

(5) Sections 3 and 4 of this paragraph do not apply to the self-referred licensee.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0025
Public Discipline

Public discipline is determined by the Board after deliberation of investigatory information. Once ordered for public discipline, there is no option for entry into HPSP. The requirements for Board ordered monitored practice are stated in the specific Board documents.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0030
Procedure for Board Referrals and Public Discipline

(1) The Board will review the report of the Investigator to determine if the licensee will be referred to the HPSP program or receive public discipline.

(2) A Board-referred licensee is enrolled in the program effective on the date the Board approves entry into the program.

(3) Upon final enrollment into the program, the vendor will notify the Board and the Board ends the ICO. The Board will dismiss, without prejudice, the complaint at the next Board meeting.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 2-2013, f. 2-28-13, cert. ef. 4-1-13; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0040
Procedure for Self- Referred Licensees

(1) Self-referred licensees may participate in the HPSP as permitted by ORS 676.190(5). Licensees with physical or cognitive impairment, without an associated Behavioral Diagnosis are not eligible to self-refer to HPSP.

(2) Once a self-referred licensee seeks enrollment in the HPSP, failure to complete final enrollment may constitute substantial non-compliance and may be reported to the Board.

(3) If self-referral has completed final enrollment to the HPSP and the Board opens an investigation on the licensee not related to substantial non-compliance, the licensee may continue in the HPSP program for the monitoring of safe practice until the Board has determined their ongoing eligibility or determined discipline.

(4) If a licensee voluntarily enters treatment without exhibiting an established danger to the public (such as workplace impairment, multiple DUII, etc.), without self-referral to HPSP, or has otherwise not had any Board reportable incidences, there is no requirement to report to the Board by the individual or the employer at the time of treatment or discovery that the licensee was in treatment, however, the licensee must disclose the treatment upon renewal of licensure.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 2-2013, f. 2-28-13, cert. ef. 4-1-13; BN 1-2014, f. 3-3-14, cert. ef. 4-1-14; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0045
Disqualification for self-referral to HPSP

(1) Reasonable expectation that a report will be made to the Board regarding work place impairment.

(2) Criminal activity involving injury or endangerment to others.

(3) A diagnosis requiring treatment because of sexual offenses or sexual misconduct.

(4) Pending or active investigations with the Board or Boards from other states.

(5) Previous failure to complete either the Nurse Monitoring Program or HPSP.

(6) Current participation in a monitoring program in another state.

(7) If during the safe practice investigation an issue is revealed that requires the HPSP program to report the issue to the Board.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0050
Disqualification Criteria for Board-referral entry into HPSP

In addition to the above, the Board may disqualify the licensee for entry into HPSP for factors including, but not limited to:

(1) Licensee's disciplinary history;

(2) Extent to which licensee's practice can be limited or managed to eliminate danger to the public;

(3) Likelihood that licensee's impairment cannot be managed with treatment;

(4) Evidence of patient harm related to the impairment;

(5) Evidence of non-compliance with a monitoring program from other state; or

(6) Previous Board investigations with findings of substantiated abuse or neglect.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 2-2013, f. 2-28-13, cert. ef. 4-1-13; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0060
Approval of Independent Third-Party Evaluators

(1) To be approved by the Board as an independent third-party evaluator, an evaluator must:

(a) Be licensed as required by the jurisdiction in which the evaluator works;

(b) Have a minimum of a Master's Degree in a mental health discipline;

(c) Provide evidence of additional education and experience as shown by one of the following:

(A) Department of Transportation Substance Abuse Professional qualification;

(B) Certified Alcohol and Drug Counselor (CADC) II or III; an evaluation done by a CADC 1 may be accepted if:

(i) Signed off by a CADC II or III; or

(ii) Per the Board evaluation process be qualified to perform the appropriate level of evaluation;

(C) Board Certified in Addiction Medicine by either ASAM or American Board of Psychiatry and Neurology.

(d) Provide evidence of assessments at the licensure level of the licensee being evaluated.

(e) The Board will not accept an evaluator as independent in a particular case if, in the Board's judgment, the evaluator's judgment is likely to be influenced by a personal or professional relationship with a licensee.

(f) If the evaluation does not contain return to work criteria, qualified Board staff or another third party evaluator will review the evaluation to determine the return to work criteria.

(2) Evaluation of cognitive or physical impairment may be established by a Licensed Independent Practitioner who has met their Licensing Board's requirement for practice in the area of physical and cognitive assessment.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0070
Approval of Treatment Providers

(1) To be approved by the Board as a treatment provider, a provider must be:

(a) Licensed as required by the jurisdiction in which the provider works;

(b) Able to provide appropriate treatment considering licensee's diagnosis, degree of impairment, level of licensure, and treatment options proposed by the treatment program or the independent third-party evaluator; and

(c) Able to obtain a urinalysis of the licensee at intake.

(2) The Board will not accept a provider as a treatment provider in a particular case if, in the Board's judgment, the provider's judgment is likely to be influenced by a personal or professional relationship with a licensee.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0075
Approval of Worksite Monitors for both HPSP and Public Discipline

To be approved by the Board as a worksite monitor, a worksite monitor must be:

(1) Licensed as a registered nurse or other licensed health professional approved by the Board.

(2) Conduct routine observation/monitoring of licensee's performance. The worksite monitor may be the supervisor if the supervisor can meet the observation requirements or this may be delegated by the supervisor to another licensed individual who meets the requirements.

(3) Provide evidence of specialized education relevant to the worksite monitor as approved by the Board.

(4) The worksite monitor must agree in writing to perform the worksite monitor role.

(5) The written report must be completed by the worksite supervisor with input from workplace monitors.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0080
Licensee Responsibilities for Self/Board referred HPSP and Public Discipline

(1) All licensees must:

(a) Agree to report any arrest for or conviction of a misdemeanor or felony crime to the HPSP and/or the Board within three business days after the licensee is arrested or convicted of the crime; and

(b) Comply continuously with his or her monitoring agreement, including any restrictions on his or her practice for a minimum of two years for the HPSP program; or, for public discipline, as specified by the Board by rule or order. During the last two years of the HPSP program only, for a single isolated incident of substantial noncompliance the Board has discretion to determine if the substantial noncompliance warrants extension in the program.

(c) Abstain from mind-altering or intoxicating substances or potentially addictive drugs, unless prescribed for a documented medical condition by a person authorized by law to prescribe the drug to the licensee. The Board does not authorize the HPSP program to approve or disapprove medications prescribed to the Licensee for a documented medical condition;

(d) Report unauthorized use of mind-altering or intoxicating substances or potentially addictive drugs within 24 hours;

(e) Comply with the treatment plan. HPSP medical director may consult with the third party evaluator(s) regarding treatment recommendations. The Board does not authorize HPSP to independently modify treatment plans developed by an Independent third-party evaluator;

(f) Limit practice as required by the Third-Party Evaluator, Treatment Program, or Board order;

(g) Participate in monitored practice;

(h) Participate in a follow-up evaluation, when necessary, of licensee's fitness to practice;

(i) Submit to random toxicology testing for the duration of the HPSP or Public Discipline program;

(j) Report at least weekly to the HPSP regarding the licensee's compliance with the monitoring agreement; report at least monthly to the Public Discipline Program compliance staff;

(k) Report to the HPSP monitor/Board compliance staff applications for licensure in other states, changes in employment and changes in practice setting;

(l) Agree to be responsible for the cost of evaluations, toxicology testing and treatment;

(m) Report to the HPSP Board compliance staff any investigations or disciplinary action by any state or state agency, including Oregon;

(n) Participate in required meetings according to the treatment plan; and

(o) Maintain active license status.

(2) In addition to the requirements listed in section one of this rule, self-referred licensees must also provide to the HPSP a copy of a report of the licensee's criminal history, at least once per calendar year or more often if required by the HPSP.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 1-2014, f. 3-3-14, cert. ef. 4-1-14; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0090
Completion Requirements

(1) To complete the HPSP successfully, licensees with a substance use disorder and with a mental disorder, must have participated in the HPSP program for a minimum of four years and have worked for at least two years in a monitored practice. Licensees must complete the required two years of monitored practice within four years of entering the HPSP.

(2) To complete the HPSP successfully, licensees with a mental health disorder, but no substance use disorder, must have participated in the HPSP program for a minimum of two years and have worked for at least one year in a monitored practice. Licensees with a mental health disorder may be required to submit to random alcohol or drug testing only in cases when such testing is recommended by a third-party evaluator or Board order based on a diagnosis of substance use disorder. Licensees must complete the required year of monitored practice within two years of entering the Health Professionals' Services Program.

(3) The Board may extend the time within which a licensee must complete monitored practice if the licensee has remained compliant with the program.

(4) A licensee who does not complete the required term of monitored practice will be discharged from the Health Professionals' Services Program and may be subject to discipline.

(5) The time spent working in monitored practice before transferring from the Nurse Monitoring Program to the Health Professionals' Services Program effective July 1, 2010, will be counted toward the required term of monitored practice.

(6) For probation, the licensee will be considered for completion as per Board order; however, the public discipline stays on the OSBN website for the life of the license.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 4-2012(Temp), f. & cert. ef. 4-26-12 thru 10-1-12; BN 13-2012, f. 7-6-12, cert. ef. 8-1-12; BN 1-2014, f. 3-3-14, cert. ef. 4-1-14; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

851-070-0100
Substantial Non-Compliance Criteria

(1) The HPSP will report substantial non-compliance to the Board within one business day after the HPSP learns of non-compliance, including but not limited to information that a licensee:

(a) Engaged in criminal behavior;

(b) Engaged in conduct that caused injury, death or harm to the public, including engaging in sexual impropriety with a patient;

(c) Was impaired in a health care setting in the course of the licensee's employment;

(d) Received a positive toxicology test result as determined by federal regulations pertaining to drug testing or self report of unauthorized substance use;

(e) Violated a restriction on the licensee's practice imposed by the HPSP or the licensee's Board;

(f) Was civilly committed for mental illness or involuntary hospitalization;

(g) Entered into a monitoring agreement with HPSP, but failed to participate or discontinued participation in HPSP;

(h) Was referred to the HPSP, but failed to enroll in the HPSP;

(i) Forged, tampered with, or modified a prescription;

(j) Violated any rules of prescriptive/dispensing authority;

(k) Violated any provisions of OAR 851-070-0080;

(l) Violated any terms of the monitoring agreement; or

(m) Failed to complete the monitored practice requirements as stated in OAR 851-070-0090.

(2) The Board, upon being notified of a licensee's substantial non-compliance will investigate and determine the appropriate sanction, which may include a limitation of licensee's practice and any other sanction, up to and including termination from the HPSP and formal discipline.

(3) For Board Ordered discipline violation of any of the conditions of the final order is considered non-compliance and will be investigated and the appropriate sanction will be determined up to and including revocation of license or certificate.

Stat. Auth.: ORS 676.200
Stats. Implemented: ORS 676.200
Hist.: BN 6-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; BN 19-2010, f. & cert. ef. 12-2-10; BN 2-2013, f. 2-28-13, cert. ef. 4-1-13; BN 1-2014, f. 3-3-14, cert. ef. 4-1-14; BN 4-2016, f. 7-15-16, cert. ef. 8-1-16

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Board of Pharmacy
Chapter 855

Rule Caption: Adopt, amend or repeal rules in Divisions 006, 025, 041, 043 and 110.
Adm. Order No.: BP 2-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Adopted: 855-006-0020, 855-043-0700, 855-043-0705, 855-043-0710, 855-043-0715, 855-043-0720, 855-043-0725, 855-043-0730, 855-043-0735, 855-043-0740, 855-043-0745, 855-043-0750
Rules Amended: 855-006-0005, 855-025-0001, 855-025-0005, 855-025-0010, 855-025-0012, 855-025-0015, 855-025-0060, 855-041-4200, 855-110-0003, 855-110-0005, 855-110-0007, 855-110-0010
Rules Repealed: 855-043-0110, 855-043-0130, 855-043-0300, 855-043-0310
Subject: Amendments in Division 006 add a definition for "Quality Assurance Plan" and establish a new rule number for "Unprofessional Conduct".

Amendments in Division 025 change the annual Certified Oregon Pharmacy Technician license to a biennial license that expires June 30th in even numbered years. Other changes are primarily housekeeping related matters or changes that correspond with biennial licensure. Changes also clarify and update the Pharmacy Technician rules.

Amendments in Division 041 are minor housekeeping changes which include an updated rule reference related to Remote Distribution Facilities.

Rules in Division 043 Practitioner Dispensing rules repeal the existing County Health Clinic and Family Planning Clinic Drug Outlet rules and establish a new section of rules to combine these two licenses into one category that will be called a Community Health Clinic Drug Outlet. A facility must register when medication dispensing is performed by a Registered Nurse (RN). The new rules provide minimum requirements of operation and define requirements for personnel, policies, and procedures, security, drug acquisition, storage of drugs, labeling, dispensing and drug delivery, disposal of drugs and recordkeeping. The new rules go into effect 7/1/16; however, facilities currently registered with the Board under the former license categories will be issued a new Community Health Clinic Drug Outlet registration upon renewal in 2017.

Amendments in Division 110 correspond with the transition to biennial licensure for Certified Oregon Pharmacy Technicians and make other minor corrections as a result of changes to various rules.
Rules Coordinator: Karen MacLean—(971) 673-0001

855-006-0005
Definitions

As used in OAR chapter 855:

(1) "Board" means the Oregon Board of Pharmacy unless otherwise specified or required by the context.

(2) "Certified Pharmacy Technician" means a person licensed by the State Board of Pharmacy who assists the pharmacist in the practice of pharmacy pursuant to rules of the Board and has completed the specialized education program pursuant to OAR 855-025-0005. Persons used solely for clerical duties, such as recordkeeping, cashiering, bookkeeping and delivery of medications released by the pharmacist are not considered pharmacy technicians.

(3) "Clinical Pharmacy Agreement" means an agreement between a pharmacist or pharmacy and a health care organization or a physician that permits the pharmacist to engage in the practice of clinical pharmacy for the benefit of the patients of the health care organization or physician.

(4) "Collaborative Drug Therapy Management" means the participation by a pharmacist in the management of drug therapy pursuant to a written protocol that includes information specific to the dosage, frequency, duration and route of administration of the drug, authorized by a practitioner and initiated upon a prescription order for an individual patient and:

(a) Is agreed to by one pharmacist and one practitioner; or

(b) Is agreed to by one or more pharmacists at a single pharmacy registered by the board and one or more practitioners in a single organized medical group, such as a hospital medical staff, clinic or group practice, including but not limited to organized medical groups using a pharmacy and therapeutics committee.

(5) "Compounding" means the preparation, mixing, assembling, packaging, or labeling of a drug or device:

(a) As the result of a practitioner's prescription drug order, or initiative based on the relationship between the practitioner, the pharmacist and the patient, in the course of professional practice; or

(b) For the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale or dispensing; or

(c) The preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns; or

(d) As a component of a Shared Pharmacy Service agreement as defined in section (21) of this rule.

(6) "Confidential Information" means any patient information obtained by a pharmacist or pharmacy.

(7) "Consulting Pharmacist" means a pharmacist that provides a consulting service regarding a patient medication, therapy management, drug storage and management, security, education, or any other pharmaceutical service.

(8) The "Container" is the device that holds the drug and that is or may be in direct contact with the drug.

(9) "Dispensing or Dispense" means the preparation and delivery of a prescription drug pursuant to a lawful order of a practitioner in a suitable container appropriately labeled for subsequent administration to or use by a patient or other individual entitled to receive the prescription drug.

(10) "Interpretation and evaluation of prescription orders" means the review of the order for therapeutic and legal correctness. Therapeutic review includes identification of the prescription drug ordered, its applicability and its relationship to the other known medications used by the patient and determination of whether or not the dose and time interval of administration are within accepted limits of safety. The legal review for correctness of the prescription order includes a determination that the order is valid and has not been altered, is not a forgery, is prescribed for a legitimate medical purpose, contains all information required by federal and state law, and is within the practitioner's scope of practice.

(11) "Labeling" means the process of preparing and affixing of a label to any drug container exclusive, however, of the labeling by a manufacturer, packer or distributor of a non-prescription drug or commercially packaged legend drug or device.

(12) "Monitoring of therapeutic response or adverse effect of drug therapy" means the follow up of the therapeutic or adverse effect of medication upon a patient, including direct consultation with the patient or his agent and review of patient records, as to result and side effect, and the analysis of possible interactions with other medications that may be in the medication regimen of the patient. This section shall not be construed to prohibit monitoring by practitioners or their agents.

(13) "Medication Therapy Management (MTM)" means a distinct service or group of services that is intended to optimize therapeutic outcomes for individual patients. Medication Therapy Management services are independent of, but can occur in conjunction with, the provision of a medication product.

(14) "Nationally Certified Exam" means an exam that is approved by the Board which demonstrates successful completion of a Specialized Education Program. The exam must be reliable, psychometrically sound, legally defensible and valid.

(15) "Non-legend drug" means a drug which does not require dispensing by prescription and which is not restricted to use by practitioners only.

(16) "Offering or performing of those acts, services, operations or transactions necessary in the conduct, operation, management and control of pharmacy" means, among other things:

(a) The creation and retention of accurate and complete patient records;

(b) Assuming authority and responsibility for product selection of drugs and devices;

(c) Developing and maintaining a safe practice setting for the pharmacist, for pharmacy staff and for the general public;

(d) Maintaining confidentiality of patient information.

(17) "Oral Counseling" means an oral communication process between a pharmacist and a patient or a patient's agent in which the pharmacist obtains information from the patient (or agent) and the patient's pharmacy records, assesses that information and provides the patient (or agent) with professional advice regarding the safe and effective use of the prescription drug for the purpose of assuring therapeutic appropriateness.

(18) Participation in Drug Selection and Drug Utilization Review:

(a) "Participation in drug selection" means the consultation with the practitioner in the selection of the best possible drug for a particular patient.

(b) "Drug utilization review" means evaluating prescription drug order in light of the information currently provided to the pharmacist by the patient or the patient's agent and in light of the information contained in the patient's record for the purpose of promoting therapeutic appropriateness by identifying potential problems and consulting with the prescriber, when appropriate. Problems subject to identification during drug utilization review include, but are not limited to:

(A) Over-utilization or under-utilization;

(B) Therapeutic duplication;

(C) Drug-disease contraindications;

(D) Drug-drug interactions;

(E) Incorrect drug dosage;

(F) Incorrect duration of treatment;

(G) Drug-allergy interactions; and

(H) Clinical drug abuse or misuse.

(19) "Pharmaceutical Care" means the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life. These outcomes include:

(a) Cure of a disease;

(b) Elimination or reduction of a patient's symptomatology;

(c) Arrest or slowing of a disease process; or

(d) Prevention of a disease or symptomatology.

(20) "Pharmacy Technician" means a person licensed by the State Board of Pharmacy who assists the pharmacist in the practice of pharmacy pursuant to rules of the Board but has not completed the specialized education program pursuant to OAR 855-025-0012.

(21) "Practice of clinical pharmacy" means:

(a) The health science discipline in which, in conjunction with the patient's other practitioners, a pharmacist provides patient care to optimize medication therapy and to promote disease prevention and the patient's health and wellness;

(b) The provision of patient care services, including but not limited to post-diagnostic disease state management services; and

(c) The practice of pharmacy by a pharmacist pursuant to a clinical pharmacy agreement.

(22) "Practice of pharmacy" is as defined in ORS 689.005.

(23) "Prescription released by the pharmacist" means, a prescription which has been reviewed by the pharmacist that does not require further pharmacist intervention such as reconstitution or counseling.

(24) "Prohibited conduct" means conduct by a licensee that:

(a) Constitutes a criminal act against a patient or client; or

(b) Constitutes a criminal act that creates a risk of harm to a patient or client.

(25) "Proper and safe storage of drugs and devices and maintenance of proper records therefore" means housing drugs and devices under conditions and circumstances that:

(a) Assure retention of their purity and potency;

(b) Avoid confusion due to similarity of appearance, packaging, labeling or for any other reason;

(c) Assure security and minimize the risk of their loss through accident or theft;

(d) Accurately account for and record their receipt, retention, dispensing, distribution or destruction;

(e) Protect the health, safety and welfare of the pharmacist, pharmacy staff and the general public from harmful exposure to hazardous substances.

(26) "Quality Assurance Plan" is a written set of procedures to ensure that a pharmacy has a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of pharmacy services and for identifying and resolving problems.

(27) "Responsibility for advising, when necessary or when regulated, of therapeutic values, content, hazards and use of drugs and devices" means advice directly to the patient, either verbally or in writing as required by these rules or federal regulation, of the possible therapeutic response to the medication, the names of the chemicals in the medication, the possible side effects of major importance, and the methods of use or administration of a medication.

(28) "Shared Pharmacy Service" means a written agreement, that has been approved in writing by the board, that exists for the processing by a pharmacy of a request from another pharmacy or a practitioner licensed to prescribe the drug, to fill or refill a prescription or a drug order, or to perform processing functions including but not limited to:

(a) Dispensing;

(b) Drug utilization review;

(c) Claims adjudication;

(d) Refill authorizations;

(e) Compounding by a pharmacy located in Oregon for a practitioner or dispenser located in Oregon for Oregon outlets and practitioners located in Oregon only; and

(f) Therapeutic interventions.

(29) "Specialized Education Program" means;

(a) A program providing education for persons desiring licensure as pharmacy technicians that is approved by the board and offered by an accredited college or university that grants a two-year degree upon successful completion of the program; or

(b) A structured program approved by the board and designed to educate pharmacy technicians in one or more specific issues of patient health and safety that is offered by:

(A) An organization recognized by the board as representing pharmacists or pharmacy technicians;

(B) An employer recognized by the board as representing pharmacists or pharmacy technicians; or

(C) A trade association recognized by the board as representing pharmacies.

(30) "Supervision by a pharmacist" means being stationed within the same work area as the pharmacy technician or certified pharmacy technician being supervised, coupled with the ability to control and be responsible for the pharmacy technician or certified pharmacy technician's action.

(31) "Therapeutic substitution" means the act of dispensing a drug product with a different chemical structure for the drug product prescribed under circumstances where the prescriber has not given clear and conscious direction for substitution of the particular drug for the one which may later be ordered.

(32) "Verification" means the confirmation by the pharmacist of the correctness, exactness, accuracy and completeness of the acts, tasks, or functions performed by an intern or a pharmacy technician or a certified pharmacy technician.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.005, 689.151, 689.155, 689.305, 689.405 & 689.455, 689.645

Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; 1PB 3-1984, f. & ef. 4-16-84; PB 2-1988, f. & cert. ef. 5-3-88; PB 2-1989, f. & cert. ef. 1-30-89; PB 4-1992, f. & cert. ef. 8-25-92; PB 1-1994, f. & cert. ef. 2-2-94; BP 4-1998, f. & cert. ef. 8-14-98; BP 1-2006, f. & cert. ef. 6-9-06; BP 12-2006, f. & cert. ef. 12-19-06; BP 2-2008, f. & cert. ef. 2-20-08; BP 6-2010, f. & cert. ef. 6-29-10; BP 3-2012, f. & cert. ef. 6-19-12; BP 8-2015, f. & cert. ef. 12-23-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-006-0020

Unprofessional Conduct Defined

"Unprofessional conduct" means conduct unbecoming of a licensee or detrimental to the best interests of the public, including conduct contrary to recognized standards of ethics of pharmacy or conduct that endangers the health, safety or welfare of a patient or client. Unprofessional conduct includes but is not limited to:

(a) Fraud or misrepresentation in dealings relating to pharmacy practice with:

(A) Customers, patients or the public;

(B) Practitioners authorized to prescribe drugs, medications or devices;

(C) Insurance companies;

(D) Wholesalers, manufactures or distributors of drugs, medications or devices;

(E) Health care facilities;

(F) Government agencies; or

(G) Drug outlets.

(b) Illegal use of drugs, medications or devices without a practitioner's prescription, or otherwise contrary to federal or state law or regulation;

(c) Any use of intoxicants, drugs or controlled substances that endangers or could endanger the licensee or others;

(d) Theft of drugs, medications or devices, or theft of any other property or services under circumstances which bear a demonstrable relationship to the practice of pharmacy;

(e) Dispensing a drug, medication or device where the pharmacist knows or should know due to the apparent circumstances that the purported prescription is bogus or that the prescription is issued for other than a legitimate medical purpose, including circumstances such as:

(A) Type of drug prescribed;

(B) Amount prescribed; or

(C) When prescribed out of context of dose.

(f) Any act or practice relating to the practice of pharmacy that is prohibited by state or federal law or regulation;

(g) The disclosure of confidential information in violation of Board rule;

(h) Engaging in collaborative drug therapy management in violation of ORS Chapter 689 and the rules of the Board;

(i) Authorizing or permitting any person to practice pharmacy in violation of the Oregon Pharmacy Act or the rules of the Board;

(j) Any conduct or practice by a licensee or registrant which the Board determines is contrary to accepted standards of practice; or

(k) Failure to cooperate with the Board pursuant to OAR 855-001-0035.

Stat. Auth.: 689.205
Stats. Implemented: ORS 689.005 and 689.155
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-025-0001
Purpose and Scope

The purpose of the Pharmacy Technician (PT) license is to provide an opportunity for an individual to obtain competency in the role as a Pharmacy Technician. This license will allow an individual time to take and pass a national pharmacy technician certification examination, which is required to be eligible for licensure as a Certified Oregon Pharmacy Technician (CPT). These rules facilitate the initial licensure of a nationally certified Pharmacy Technician seeking licensure in Oregon.

Stat. Auth.: 689.205
Stats. Implemented: 689.225, 689.486
Hist.: BP 8-2005, f. 12-14-05, cert. ef. 12-15-05; BP 1-2006, f. & cert. ef. 6-9-06; BP 10-2014, f. 12-30-14, cert. ef. 1-1-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-025-0005
Qualifications for Licensure as a Pharmacy Technician or Certified Oregon Pharmacy Technician

(1) To qualify for licensure as a Pharmacy Technician or Certified Oregon Pharmacy Technician, an applicant must demonstrate that the applicant is at least 18 years of age and has obtained a high school diploma or GED.

(2) Section one does not apply to persons under the age of 18 licensed by the Board as a Pharmacy Technician prior to January 1, 2015.

(3) An applicant for licensure as a Pharmacy Technician or Certified Oregon Pharmacy Technician must complete an application for licensure, provide the Board with a valid e-mail address and furnish documentation required to conduct a criminal background check.

(4) No person whose license has been denied, revoked, suspended or restricted by any healthcare professional regulatory Board may be licensed as a Pharmacy Technician or Certified Oregon Pharmacy Technician unless the Board determines that licensure will pose no danger to patients or to the public interest.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.225, 689.486
Hist.: BP 1-2006, f. & cert. ef. 6-9-06; BP 10-2014, f. 12-30-14, cert. ef. 1-1-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-025-0010
Licensure as a Pharmacy Technician

(1) The license of a Pharmacy Technician expires the second June 30 from the date of issue and is not to exceed two years.

(2) The Pharmacy Technician license is not renewable.

(3) A time limited extension of a Pharmacy Technician license may be granted once by petition to the Board. The written completed petition must be received by the Board prior to the expiration of the PT license.

(4) An individual may reapply for a Pharmacy Technician license if the previous PT license is lapsed for a period greater than five years.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.225, 689.486
Hist.: BP 1-2006, f. & cert. ef. 6-9-06; BP 10-2014, f. 12-30-14, cert. ef. 1-1-15; BP 4-2015, f. & cert. ef. 7-1-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-025-0012
Licensure as a Certified Oregon Pharmacy Technician

(1) To qualify for licensure as a Certified Oregon Pharmacy Technician, the applicant must demonstrate that he or she has taken and passed a national pharmacy technician certification examination offered by:

(a) The Pharmacy Technician Certification Board (PTCB); or

(b) The National Healthcareer Association (NHA).

(2) The license of a Certified Oregon Pharmacy Technician expires June 30 in even numbered years and must be renewed biennially.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.225, 689.486
Hist.: BP 10-2014, f. 12-30-14, cert. ef. 1-1-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-025-0015
Renewal of Licensure as a Certified Oregon Pharmacy Technician

(1) A person who has taken and passed a national pharmacy technician certification examination listed in OAR 855-025-0012(1)(a)–(b) may use the following title, and is referred to in these rules as, and is licensed as a "Certified Oregon Pharmacy Technician."

(2) An applicant for renewal of a Certified Oregon Pharmacy Technician license must:

(a) Pay the biennial license fee prescribed in OAR 855-110.

(b) Satisfactorily complete a minimum of 20 continuing pharmacy educating hours during the period from July 1 through June 30, of each license renewal cycle. These hours must include:

(A) Two hours of continuing pharmacy education in pharmacy law;

(B) Two hours of continuing pharmacy education in patient safety or error prevention; and

(C) Sixteen other hours of continuing pharmacy education or documented onsite training approved by the Board.

(c) OAR 855-025-0015(2)(b) does not apply to a Certified Oregon Pharmacy Technician applying for the first renewal of their license, if they have not been licensed by the Board for at least one year prior to July 1 of the renewal period.

(d) Be subject to an annual criminal background check.

(3) The Board may randomly select and audit applications for renewal to verify completion of continuing education or documented onsite training reported on the application for renewal. A Certified Oregon Pharmacy Technician whose application for renewal is selected for audit must provide documentation of completion of the continuing pharmacy education reported.

(4) Effective January 1, 2015, national certification is not required to renew a license as a Certified Oregon Pharmacy Technician.

(5) A Certified Oregon Pharmacy Technician who fails to renew his or her license by the expiration date and whose license has been lapsed for less than one year may renew his or her license as follows:

(a) Complete the renewal process;

(b) Pay the biennial license fee as prescribed in OAR 855-110;

(c) Pay a delinquent fee; and

(d) Complete the required continuing education pursuant to OAR 855-025-0015(2)(b).

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.225, 689.486
Hist.: BP 1-2006, f. & cert. ef. 6-9-06; BP 10-2014, f. 12-30-14, cert. ef. 1-1-15; BP 6-2015(Temp), f. & cert. ef. 8-21-15 thru 2-16-16; BP 8-2015, f. & cert. ef. 12-23-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-025-0060
Reinstatement of a Certified Oregon Pharmacy Technician License

(1) A Certified Oregon Pharmacy Technician who fails to renew their license by the deadline and whose license has been lapsed for greater than one year may reinstate their license as follows:

(a) Complete a new application for licensure and provide the Board with a valid e-mail address;

(b) Pay the biennial license fee as prescribed in OAR 855-110;

(c) Submit to a national fingerprint background check; and

(d) Provide certification of completion of 10 continuing education hours. These hours may not be counted toward renewal; and must include:

(A) One hour of continuing pharmacy education in pharmacy law;

(B) One hour of continuing pharmacy education in patient safety or error prevention; and

(C) Eight other hours of pharmacy technician-specific continuing education.

(2) A Certified Oregon Pharmacy Technician whose license has been lapsed greater than five years must:

(a) Re-take and pass a national pharmacy technician certification examination offered by:

(A) The Pharmacy Technician Certification Board (PTCB); or

(B) National Healthcareer Association (NHA).

(b) Satisfy reinstatement requirements pursuant to OAR 855-025-0060(1).

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.225, 689.486
Hist.: BP 1-2006, f. & cert. ef. 6-9-06; BP 10-2014, f. 12-30-14, cert. ef. 1-1-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-041-4200
Remote Distribution Facility (RDF)

(1) A pharmacy physically located in Oregon may make written application to operate an RDF.

(2) The Board may approve an application for registration as an RDF which includes the following:

(a) An operation plan;

(b) Policies and Procedures;

(c) A training plan;

(d) A quality assurance plan for ensuring that there is a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of pharmacy services and for identifying and resolving problems; and

(e) The fee specified in OAR 855-110.

(3) Notwithstanding the definition of "supervision by a pharmacist" in OAR 855-006-0005, supervision in an RDF may be accomplished by a pharmacist via an audio-visual technology from the applying pharmacy.

(4) Notwithstanding rules in this division and in divisions 19 and 25, a Certified Oregon Pharmacy Technician who works in an RDF may have access to the facility without the physical presence of a pharmacist, but may only perform Board approved functions when under the supervision of a pharmacist.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 3-2011, f. & cert. ef. 4-18-11; Renumbered from 855-041-0645, BP 7-2012, f. & cert. ef. 12-17-12; BP 1-2014, f. & cert. ef. 1-3-14; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0700
Purpose and Scope

(1) The purpose of 855-043-0700 to 855-043-0750 is to provide minimum requirements of operation for a Community Health Clinic (CHC) to utilize a Registered Nurse to dispense medications. A Community Health Clinic Drug Outlet registration replaces a Family Planning or County Health Drug Outlet registration. A legend or non-prescription drug may be dispensed to a client for the purpose of birth control, caries prevention, the treatment of amenorrhea, the treatment of a communicable disease, hormone deficiencies, urinary tract infections or sexually transmitted diseases by a practitioner who has been given dispensing privileges by their licensing Board, or a Registered Nurse, who is an employee of a clinic or local public health authority (LPHA), and is recognized by the Oregon Public Health Division for the purposes of providing public health services.

(2) Dispensing must be pursuant to the order or prescription of a person authorized by their Board to prescribe a drug or established by the Medical Director or clinic practitioner with prescriptive and dispensing authority.

(3) Family Planning or County Health Clinic registrations that expire March 31, 2017 will be converted to the CHC category upon renewal in 2017. However, rules take effect on July 1, 2016.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0705
Registration

(1) A Community Health Clinic Drug Outlet must register with the Board on a form prescribed by the Board, and must renew its registration annually on a renewal form prescribed by the Board.

(2) An initial application and renewal application must be accompanied by the fee established in division 110 of this Chapter.

(3) A certificate of registration will be issued upon Board approval of the application.

(4) The CHC Drug Outlet registration expires March 31, annually. If the annual renewal fee is not paid by February 28 of the current year, the applicant for renewal must submit the delinquent fee established in division 110 of this Chapter with the renewal application.

(5) The registration is not transferable and the registration fee cannot be prorated.

(6) The registrant must notify the Board, within 15 days, of any substantial change to the information provided on the registration application. A substantial change shall include but not be limited to: a change of ownership; change of business address; change of normal business hours; any disciplinary action taken or pending by any state or federal authority against the registrant, or any of its principals, owners, directors, officers, or Medical Director.

(7) A new registration form is required for a change of ownership or location and must be submitted to the Board with the fees as specified in division 110 of this Chapter within 15 days of the change.

(8) A CHC Drug Outlet may be inspected by the Board.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0710
Personnel

(1) A Community Health Clinic Drug Outlet must employ a Medical Director who is an Oregon practitioner with prescriptive and dispensing authority. The Medical Director shall establish and enforce policies and procedures, drug dispensing formulary, and protocols for the dispensing of drugs by authorized persons in the CHC.

(2) A CHC Drug Outlet must designate a representative employee who will act as the contact person for the Oregon Board of Pharmacy. The designated representative must be onsite the majority of the CHC's normal operating hours.

(a) The Medical Director or designated representative must conduct and document an annual review of the outlet on a form provided by the Board. The completed report must be filed in the outlet, retained on file for three years and be available to the Board for inspection.

(b) The Medical Director shall develop policies and procedures for the outlet in collaboration with the designated representative.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0715
Policies and Procedures

The Community Health Clinic must:

(1) Maintain written policies and procedures for drug management, including security, acquisition, storage, dispensing and drug delivery, disposal, and record keeping.

(2) Establish procedures to train a Registered Nurse employed by the CHC to ensure continued competence in the dispensing of drugs.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0720
Security

(1) All drugs must be kept in a locked drug cabinet or designated drug storage area that is sufficiently secure to deny access to unauthorized persons. The drug cabinet or designated drug storage area must remain locked and secured when not in use.

(2) Only a Physician, Clinical Nurse Specialist, Nurse Practitioner, or Registered Nurse shall have a key to the drug cabinet or drug room. In their absence, the drug cabinet or drug room must remain locked.

(3) Upon written request, the Board may waive any of the requirements of this rule if a waiver will further public health or safety or the health and safety of a patient. A waiver granted under this section shall only be effective when it is issued by the Board in writing.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0725
Drug Acquisition

The CHC must verify that all drugs are acquired from a registrant of the Board.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0730
Storage of Drugs

All drugs, including drug samples, must be stored according to the manufacturer's published guidelines and be stored in appropriate conditions of temperature, light, humidity, sanitation, ventilation, and space.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0735
Labeling

(1) A prescription must be labeled with the following information:

(a) Unique identifier (i.e. prescription number);

(b) Name of patient;

(c) Name of prescriber;

(d) Name, address, and phone number of the clinic;

(e) Date of dispensing;

(f) Name of drug, strength, and quantity dispensed; when a generic name is used, the label must also contain the identifier of the manufacturer or distributor;

(g) Quantity dispensed;

(h) Directions for use;

(i) Initials of the practitioner who has been given dispensing privileges by their licensing Board or the Registered Nurse;

(j) Cautionary statements, if any, as required by law; and

(k) Manufacturer's expiration date, or an earlier date if preferable, after which the patient should not use the drug.

(2) Notwithstanding any other requirements in this rule, when a drug is dispensed in the practice of an Expedited Partner Therapy treatment protocol, the name of the patient may be omitted from the label, the patient's name may be omitted from the records and a drug may be dispensed to the patient to be given to the patient's partner even if the partner has not been examined by a licensed health care provider acting within their scope of practice.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0740
Dispensing and Drug Delivery

(1) A drug may only be dispensed by a practitioner who has been given dispensing privileges by their licensing Board or by a Registered Nurse.

(2) A Registered Nurse may only provide over-the-counter drugs pursuant to established CHC protocols.

(3) A Registered Nurse may only dispense a drug listed in, or for a condition listed in, the formulary.

(4) Nonjudgmental dispensing functions may be delegated to staff assistants when the accuracy and completeness of the prescription is verified by a practitioner who has been given dispensing privileges by their licensing Board, or by a Registered Nurse, prior to being delivered or transferred to the patient.

(5) The CHC will provide appropriate drug information for medications dispensed to a patient, which can be provided by the Registered Nurse or practitioner at the time of dispensing.

(6) All drugs must be dispensed in a new container that complies with the current provisions of the Federal Consumer Packaging Act (Public Law 91-601, 91st Congress, S. 2162) and rules or regulations and with the current United States Pharmacopoeia/National Formulary monographs for preservation, packaging, storage and labeling.

(7) Drugs must be repackaged by the practitioner, Registered Nurse, a pharmacy; or a manufacturer registered with the Board.

(8) A CHC may not accept the return of drugs from a previously dispensed prescription and must maintain a list of sites in Oregon where drugs may be disposed.

(9) A CHC must have access to the most current issue of at least one pharmaceutical reference with current, properly filed supplements and updates appropriate to and based on the standards of practice for the setting.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0745
Disposal of Drugs

Drugs that are outdated, damaged, deteriorated, misbranded, adulterated, or identified as suspect or illegitimate must be documented, quarantined and physically separated from other drugs until they are destroyed or returned to the supplier.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-043-0750
Record Keeping

(1) A dispensing record must be maintained separately from the patient chart and kept for a minimum of three years. The record must show, at a minimum, the following:

(a) Name of patient;

(b) Unique identifier (i.e. prescription number);

(c) Dose, dosage form, quantity dispensed and either the brand name of drug, or generic name and name of manufacturer or distributor;

(d) Directions for use;

(e) Date of dispensing; and

(f) Initials of person dispensing the prescription.

(2) All records of receipt and disposal of drugs must be kept for a minimum of three years.

(3) All records required by these rules or by other State and federal law must be readily retrievable and available for inspection by the Board.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.305
Hist.: BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

855-110-0003
General

(1) All fees paid under these rules are non-refundable.

(2) Fees cannot be prorated.

(3) Fees for initial licensure as a Pharmacist or Certified Oregon Pharmacy Technician may be reduced to one half of a biennial rate, if the application is received or the mailing date of the application is postmarked within 180 days of expiration.

(4) A delinquent fee must be paid:

(a) When an application is postmarked after the date specified in these rules; or

(b) When the Board requests additional information from an applicant and this information is not provided within 30 days.

(5) A delinquent fee may be assessed when an application is submitted incomplete and the Board requests the missing information.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.135
Hist.: 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 13-2014, f. 12-30-14, cert. ef. 4-1-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

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

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

(6) Pharmacist:

(a) Biennial license fee. Expires June 30 each odd numbered year. The biennial license fee is — $120. Delinquent renewal fee, (postmarked after May 31) — $50.

(b) Electronic Prescription Monitoring Fund fee. Due by June 30 biennially— $50. (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 — $4. (This is a mandatory fee 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) Pharmacy Technician license fee — $50.

(a) A Pharmacy Technician license initially issued prior to January 1, 2015 to a person under 18 years of age expires June 30 in odd numbered years — $50. Delinquent renewal fee, (postmarked after May 31) — $20.

(9) Certified Oregon Pharmacy Technician:

(a) Biennial license fee. Expires June 30 each even numbered year — $50. Delinquent renewal fee, (postmarked after August 31) — $20.

(b) Workforce Data Collection fee. Due by June 30 biennially — $4. (This is a mandatory fee as required by OAR 409-026-0130 that must be paid with the Certified Oregon Pharmacy Technician license renewal fee.

Stat. Auth.: ORS 689.205 & 291.055 & 183.705

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 1-5-14; BP 7-2013, f. & cert. ef. 9-23-13; BP 1-2014, f. & cert. ef. 1-3-14; BP 13-2014, f. 12-30-14, cert. ef. 4-1-15; BP 4-2015, f. & cert. ef. 7-1-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

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

(1) Community Health Clinic. 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) Manufacturers (including Manufacturer Class I, Manufacturer Class II and Manufacturer Class III). 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) Wholesalers (including Wholesaler Class I, Wholesaler Class II and Wholesaler Class III). Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(13) Remote Dispensing Machine or Remote Distribution Facility. Expires March 31 annually — $100. Due by February 28 annually.

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

(15) 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.

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

Stat. Auth.: ORS 689.205 & 291.055
Stats. Implemented: ORS 689.135, 689.774 & 2689.305
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 1-5-14; BP 7-2013, f. & cert. ef. 9-23-13; BP 1-2014, f. & cert. ef. 1-3-14; BP 4-2015, f. & cert. ef. 7-1-15; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

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 Distribution 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; BP 4-2013(Temp), f. & cert. ef. 7-9-13 thru 1-5-14; BP 7-2013, f. & cert. ef. 9-23-13; BP 2-2016, f. 6-30-16, cert. ef. 7-1-16

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Citizens' Initiative Review Commission
Chapter 710

Rule Caption: Independent Expert Panelists for Citizens' Initiative Reviews
Adm. Order No.: CIRC 1-2016
Filed with Sec. of State: 6-20-2016
Certified to be Effective: 6-20-16
Notice Publication Date: 5-1-2016
Rules Adopted: 710-015-0000
Subject: According to the duties defined in ORS 250.139(6)(e), the Commission shall establish a panel of experts independent of campaigns supporting or campaigns opposing the measure to provide testimony or other information to the citizen panel.
Rules Coordinator: Sarah Giles—(503) 725-5248

710-015-0000
Independent Expert Panelists

According to the duties defined in ORS 250.139(6)(e), the Commission shall establish a panel of experts independent of campaigns supporting or campaigns opposing the measure to provide testimony or other information to the citizen panel.

Stat. Auth.: ORS 250.137(3)(a) & 250.139(6)(d) & (e) & 2014 OL Ch. 72, Sec. 2
Stats. Implemented: ORS 250.137(3)(a) & 250.139(6)(d) & (e) & 2014 OL Ch. 72, Sec. 2
Hist.: CIRC 1-2016, f. & cert. ef. 6-20-16

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Department of Administrative Services, Chief Human Resources Office
Chapter 105

Rule Caption: Amending and repealing rules to include legislative changes and statutory requirements.
Adm. Order No.: CHRO 2-2016
Filed with Sec. of State: 6-22-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 105-020-0001, 105-020-0015, 105-040-0001, 105-050-0003, 105-050-0004, 105-050-0025, 105-050-0030
Rules Repealed: 105-010-0000, 105-010-0011, 105-010-0016, 105-040-0010, 105-040-0020, 105-040-0030, 105-040-0040(T), 105-

040-0050, 105-040-0060, 105-040-0065(T), 105-040-0070, 105-040-0080, 105-050-0006

Subject: The rule changes are based on a number of factors including legislative changes as well as statutory requirements, as cited below.

Division 10 - Definitions are being repealed and moved to CHRO policy, while the other rules in this division are being repealed due to statutory changes.

Division 20 - Changes to this chapter include revisions to compensation language due to statutory updates.

Division 40 - The majority of this chapter is being repealed and moved to policy, as there are no statutory requirements to develop, implement or maintain rules in this area. The remaining rules are being amended to reflect statutory changes and updated references.

Division 50 - This chapter is being amended to reflect statutory changes and federal requirements for these subjects. Rules repealed in this section are due to authority changes in responsibility residing with specific agencies.

Rules Coordinator: Janet Chambers—(503) 378-5522

105-020-0001
Comparability of Work

(1) The Department of Administrative Services (DAS) shall use the Hay Method of job evaluation as the neutral and objective method to determine the comparability of the value of work performed by employees in the classified services within the State Executive Branch and the compensation and classification structure of the state system.

(2) DAS shall use a neutral and objective method to determine the comparability of the value of work performed by State Executive Branch employees in unclassified and management service, except those employees and agencies identified in ORS 240.240 as exempt from ORS 240.240. DAS shall use this method to determine the compensation and classification system for these categories or service, pursuant to ORS 292.951.

Stat. Auth.: ORS 184.340, 240.145, 240.250
Stats. Implemented: ORS 240.190, ORS 240.235, 240.240, 240.245, 292.951, 292.956
Hist.: PD 4-1988, f. & cert. ef. 4-29-88; PD 2-1989, f. & cert. ef. 12-1-89; PD 2-1994, f. & cert. ef. 8-1-94, Renumbered from 105-030-0095; HRSD 8-2003, f. 5-15-03, cert. ef. 5-21-03; CHRO 2-2016, f. 6-22-16, cert. ef. 7-1-16

105-020-0015
"Pick-up" of Employee Contributions to Retirement

(1) The Department of Administrative Services shall treat any employee contribution to PERS from the employees' salaries as the employer's contribution, thus "picking up" that contribution for purposes of Internal Revenue Code Section 414(h)(2).

(2) The contribution shall be deducted directly from the employee's wages and the employee shall not have the option of receiving his or her contribution as salary and of making the contribution himself or herself.

(3) The employee's reported salary on the W-2 form for tax purposes shall be reduced by the amount of that contribution.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184.340, 240.145(3), 240.250, 26 USC § 414(h)
Stats. Implemented: ORS 238.200, 238.205, EO 94-23 & 26 USC § 414(h)
Hist.: PD 3-1994(Temp), f. 12-23-94, cert. ef. 1-1-95; PD 1-1995, f. 3-31-95, cert. ef. 4-1-95; CHRO 2-2016, f. 6-22-16, cert. ef. 7-1-16

105-040-0001
Equal Employment Opportunity and Affirmative Action

(1) Oregon State Government is committed to achieving a workforce that represents the diversity of the Oregon community and being a leader in providing its citizens with fair and equal employment opportunities. Accordingly:

(a) State agency heads shall ensure:

(A) Equal employment opportunities are afforded to all applicants and employees by making non-discriminatory employment related decisions;

(B) Employment practices shall be in compliance with the state's Affirmative Action Guidelines, state and federal laws to:

(i) Promote good faith efforts to achieve established affirmative action objectives; and

(ii) Take proactive steps to develop diverse applicant pools for position vacancies.

(b) The Department of Administrative Services (DAS) shall:

(A) Maintain an automated affirmative action tracking system which uses a uniform methodology for communicating affirmative action objectives for each state agency.

(B) Produce periodic reports showing Oregon State Government's progress toward achieving established affirmative action objectives identified by the Chief Human Resources Office at DAS and the Governor's Office of Diversity and Inclusion.

(c) Persons, who believe they have been subjected to discrimination by an agency in violation of this rule, may file a complaint with the agency's affirmative action representative within 365 calendar days of the alleged act or upon knowledge of the occurrence.

(2) Employment related decisions include, but are not limited to:

(a) Hiring,
(b) Promotion,
(c) Demotion,
(d) Transfer,
(e) Termination,
(f) Layoff,
(g) Training,
(h) Compensation,
(i) Benefits, and
(j) Performance evaluations;

(3) Diverse applicant pools are developed by using proactive outreach strategies.

(4) This rule does not preclude any person from filing a formal complaint in accordance with a collective bargaining agreement, or with appropriate state or federal agency under the applicable law.

Stat. Auth.: ORS 184.340, 240.145, 240.250
Stats. Implemented: ORS 240.306, 659A.012 - 659A.015
Hist.: PD 2-1994, f. & cert. ef. 8-1-94; HRSD 11-2003, f. 7-15-03, cert. ef. 7-21-03; HRSD 2-2008, f. & cert. ef. 11-4-08; CHRO 2-2016, f. 6-22-16, cert. ef. 7-1-16

105-050-0003
Alcohol and Controlled Substance Testing of Employees Having Commercial Drivers License

(1) To promote public and employee health, safety and productivity, agency heads shall apply to management service and classified unrepresented employees required to have a Commercial Driver's License (CDL):

(a) Federal Motor Carrier Safety Administration rules stated in 49 CFR Part 382 requiring pre-employment, post-accident, random, reasonable suspicion, return-to-duty and follow-up testing for alcohol or controlled substances; and

(b) U.S. Department of Transportation rules stated in 49 CFR Part 40 which provide procedures for alcohol testing, controlled substance testing, split specimen testing and urine specimen testing.

(2) An agency head shall approve the Alcohol and Drug Testing Contract between the Department of Administrative Services (DAS) and the vendor for the performance of alcohol and controlled substance testing, Substance Abuse Professional Services, Medical Review Officer Services, record keeping and other related service.

(3) An agency head shall provide or contract for training and educational materials as required by 49 CFR Part 382.601, 382.603 and 382.605.

(4) Except as otherwise provided in 49 CFR Part 382.505 regarding alcohol test results of 0.02 to 0.039, an employee who violates alcohol misuse or controlled substance use rules may be terminated by an agency head or, if not terminated, shall be removed from duties requiring a CDL and shall be evaluated by a substance abuse professional to assess any need for rehabilitation or treatment and, as determined to be appropriate by the agency head, may be assigned to duties not requiring a CDL, granted leave with or without pay at employee request, or disciplined.

(5) Any employee rehabilitation or treatment shall be at employee expense except as it may be covered by insurance. Leave with or without pay may be granted at employee request during the period of treatment or rehabilitation as stated in 40 CFR 40.289.

(6) As stated in 49 CFR 40.305, except as otherwise provided in 49 CFR Part 382.505 regarding alcohol test results of 0.02 to 0.039, an agency head may return an employee, who violates alcohol misuse or controlled substance use rules, to the former duties requiring a CDL if the employee:

(a) Has been evaluated by a substance abuse professional;

(b) Has complied with the recommended treatment or rehabilitation;

(c) Has taken a return to duty alcohol or controlled substance test and has a negative result; and

(d) Is subject to unannounced follow-up alcohol or controlled substance tests.

(7) An employee having a CDL shall inform the appointing authority of any medial use of controlled substances.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: Omnibus Transportation Employee Testing Act of 1991; 49 CFR 392.4 and 392.5, ORS 184.340, 240.145, 240.250
Stats. Implemented: ORS 813.403, 813.404
Hist.: PD 4-1994, f. 12-23-94, cert. ef. 1-1-95; CHRO 2-2016, f. 6-22-16, cert. ef. 7-1-16

105-050-0004
Drug Testing of Final Applicants for Certain State Classifications/Positions

(1) Oregon State Government provides the public with a drug-free workplace.

(a) An appointing authority of an agency providing public safety, mental health services or positions meeting the federal standards for drug testing, may institute a drug testing program for the final applicant for classifications and/or positions designated by the appointing authority. A final applicant is the employing agency's first choice, prior to an offer of employment, but after completion of all hiring tests and standards, including reference and criminal records checks, when applicable.

(b) Prior to implementing the drug testing program for the final applicant the appointing authority shall develop an agency drug testing policy which shall include:

(A) The designated classifications and/or positions for which the final applicant shall be tested for prohibited drugs;

(B) The prohibited drugs/controlled substances for which a final applicant shall be tested;

(C) Assurance that the drug testing shall be conducted by a laboratory which is licensed and operated in accordance with ORS 438.010 and OAR 333-024-0305 through 333-024-0350;

(D) A description of the drug testing protocol, i.e., how and when the drug testing shall be carried out.

(c) An appointing authority shall not select a final applicant who refuses to take or fails a test for prohibited drug use.

(d) An applicant disqualified for a current opening may reapply for subsequent openings for those positions designated for pre-employment drug testing:

(A) Upon presenting proof of successful completion of a drug rehabilitation program; or

(B) Passing any drug test required for the final applicant for subsequent openings.

(e) Drug tests for the final applicant shall be paid for by the hiring agency and conducted in accordance with the agency's drug testing policy.

(f) At the time of implementation, an appointing authority shall submit a copy of the agency drug testing policy for the final applicant to the agency's Human Resources Office for filing.

(g) All recruiting announcements for designated classifications/positions shall include the statement: "All applicants for, and employees in this classification/position, shall be subject to testing for the use of prohibited drugs."

(h) An appointing authority shall maintain records of drug testing, stating the number of applicants tested, the number of confirmed positive tests and the classifications/positions involved.

(i) An agency's administration of its drug testing policy and drug testing records for applicants shall be subject to audit by the Chief Human Resources Office.

(2) Failing a drug test means the confirmation test result indicates positive evidence of a prohibited drug.

(3) Prohibited drugs are specified in Schedules I through V of Section 202 of the Controlled Substances Act, 21 USC 811, 812 and as defined in 21 CFR 1300.11 through 1300.15 unless authorized by legal prescription or are exempt from federal or state law.

(4) For the purpose of this rule, public safety services are those performed by police officers, firefighters, public safety trainers, correctional officers, group life coordinators at juvenile corrections institutions, parole and probation officers, strike-prohibited employees at mental health institutions and services performed by other strike-prohibited employees.

(5) For purpose of this rule, positions within the agencies, subject to federal standards, may be subject to pre-employment drug testing.

Stat. Auth.: ORS 184.340, 240.145, 240.250
Stats. Implemented: ORS 240.135, 240.321
Hist.: HRMD 1-1996, f. & cert. ef. 1-31-96; HRSD 9-2003, f. 5-15-03, cert. ef. 5-21-03; CHRO 2-2016, f. 6-22-16, cert. ef. 7-1-16

105-050-0025
Injured Worker Preference for Light Duty Assignments

(1) Definitions:

(a) Agency-at-injury: The state agency that employed the injured worker when the compensable injury occurred.

(b) Attending Physician: The physician primarily responsible for the injured worker's care related to the compensable condition in the workers' compensation claim.

(c) Independent and semi-independent agencies: State executive branch agencies not subject to all of ORS 240.

(d) Light duty assignment: A transitional assignment of an injured worker while the worker is recovering from job-related injuries or illnesses to duties within the worker's capacities and restrictions specified in writing by the worker's attending physician.

(2) If feasible, agencies-at-injury will make light duty assignments for injured workers after an attending physician authorizes a worker to return to work with temporary restrictions that preclude the worker from performing some or all of the worker's regular job duties.

(3) To identify light duty assignments, agencies-at-injury:

(a) Where feasible, temporarily modify a worker's regular job duties by removing or modifying those duties that conflict with physical restrictions specified by an injured worker's attending physician.

(b) If it is not feasible to remove or modify the worker's regular job duties to be consistent with the worker's restrictions, the agency-at-injury considers other work the agency may temporarily assign to the injured worker.

(c) If no light duty assignments are available within the agency-at-injury, the agency-at-injury may contact the Chief Human Resources Office (CHRO) or other executive branch agencies for assistance in locating light duty assignments.

(d) Agencies-at-injury monitor, adjust, or terminate temporary light duty assignments as appropriate.

(e) An injured worker temporarily assigned light duty work in another agency remains an employee of the agency-at-injury.

(f) CHRO may develop policies to implement this rule.

Stat. Auth.: ORS 240.145, 240.250, 659A.052
Stats. Implemented: ORS 240.306, 659A.043, 659A.046, 659A.052
Hist.: HRSD 1-2009(Temp), f. 6-25-09, cert. ef. 7-1-09 thru 12-27-09; HRSD 2-2009(Temp), f. & cert. ef. 11-2-09 thru 2-28-10; HRSD 3-2009, f. 12-30-09, cert. ef. 1-1-10; CHRO 2-2016, f. 6-22-16, cert. ef. 7-1-16

105-050-0030
Injured Worker Preference for Entry-Level Positions

(1) Definitions:

(a) Agency-at-injury: The state agency that employed the injured worker when the compensable injury occurred.

(b) Attending Physician: The physician primarily responsible for the injured worker's care related to the compensable condition in the workers' compensation claim.

(c) Independent and semi-independent agencies: State executive branch agencies not subject to all of ORS 240.

(d) Entry-level position: All limited competitive and non-competitive appointment classifications listed in OAR 105-040-0060; all classifications defined as entry in their title; single-level classifications and the first level of a classification series.

(2) Injured workers who make a timely demand for reemployment to available, suitable employment in accordance with Oregon Administrative Rule 839-006-0135 may also request consideration for permanent appointment to entry-level positions.

(a) The injured worker, seeking such reemployment, submits a written request to the agency-at-injury noting the specific entry-level positions to which he or she seeks appointment along with an updated employment application form.

(b) An agency-at-injury, subject to ORS 240, after receiving an eligible injured worker's request for permanent reemployment in a suitable or entry-level position, places the injured worker on the injured worker list for suitable and entry-level positions.

(c) The Chief Human Resources Office provides relevant information to semi-independent and independent state agencies regarding the injured workers who are eligible for reemployment to available, suitable, and entry-level positions.

(d) Independent and semi-independent state agencies give priority consideration according to subsection (2)(f) of this rule, to injured workers from other executive branch agencies who make a timely demand for reemployment.

(e) CHRO places workers injured in an independent or semi-independent agency on the injured worker list for appropriate classifications following receipt of notice from an independent or semi-independent agency of the injured worker's timely demand for reemployment to suitable and entry-level positions.

(f) All executive branch agencies, when filling vacancies, subject to the restrictions of an applicable collective bargaining agreement, offer entry-level and suitable positions to injured workers who meet the minimum and special qualifications of the position and can perform the duties within permanent restrictions.

Stat. Auth.: ORS 240.145, 240.250, 659A.052
Stats. Implemented: ORS 240.306, 659A.043, 659A.046, 659A.052

Hist.: HRSD 1-2009(Temp), f. 6-25-09, cert. ef. 7-1-09 thru 12-27-09; HRSD 2-2009(Temp), f. & cert. ef. 11-2-09 thru 2-28-10; HRSD 3-2009, f. 12-30-09, cert. ef. 1-1-10; CHRO 2-2016, f. 6-22-16, cert. ef. 7-1-16

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Department of Agriculture
Chapter 603

Rule Caption: Amends rules regarding the Grade A Pasteurized Milk Ordinance, sediment testing, drug residues, and storage.
Adm. Order No.: DOA 13-2016
Filed with Sec. of State: 6-20-2016
Certified to be Effective: 6-20-16
Notice Publication Date: 5-1-2016
Rules Amended: 603-024-0017, 603-024-0041, 603-024-0211, 603-024-0594, 603-024-0641
Subject: This rule proposal uopdates Oregon Administrative Rules (OAR) to reference the 2015 Grade A Pasteurized Milk Ordinance (PMO) and its accompanying documents. The PMO outlines the federally mandated minimum requirements for Grade A milk production and processing. It is released on a biennial basis after amendments and standards are recommended through the National Conference on Interstate Milk Shipments (NCIMS). State and local regulatory officials make the recommendations and vote. Nonvoting representatives from industry, academia, and U.S. Food and Drug Administration (FDA) also participate in the NCIMS. After the NCIMS, the FDA accepts or rejects the proposed changes before releasing a new PMO. States then have the opportunity to adopt the PMO. In order for Oregon's dairy industry to participate in the interstate commerce of Grade A dairy products, the PMO must be adopted as a minimum. This rule will help to ensure that Oregon's dairy industry will be able to continue interstate activiites.

This rule proposes revisions to several other rules within Oregon's dairy product rules. First, is the removal of the No. 2 sediment test for Grade A Raw Goat Milk. This test is no longer used in a regulatory manner in Oregon. Second, the procedures and enforcment of drug residue tests need to be clarified to promote consistency with the PMO and Oregon rules. Previously, when a positive drug residue test was found, all milk production was stopped for 48 hours or four milkings. However, with modern scientific analysis, it is possible to continually test the milk for drug residues, and safe to allow milk production and sale to continue as soon as the milk tests negative for drug residues. This rule proposes to make that change, and also proposes clarifying language regarding when a suspension of grade designation can occur. Finally, the rule proposes to allow Grade A raw milk to be picked up at a minimum of once each 72 hours, and require a farm bulk tank to be completeley emptied once each 72 hours. Both of the 72 hour time requirements was 48 hours previously.
Rules Coordinator: Sue Gooch—(503) 986-4583

603-024-0017
Standards of Identity, Quantity and Labeling Requirements

(1) The weights and measures packaging and labeling requirements for butter, fluid milk and milk products shall be those specified in OAR 603-027-0105, and the weights and measures requirements as to the methods of sale of butter, milk and milk products shall be those specified in OAR 603-027-0206.

(2) Labeling, standards of identity and marking requirements for butter, fluid milk and milk products not provided for under section (1) of this rule, shall be those specified in the Grade "A" Pasteurized Milk Ordinance, 2015 Revision.

(3) Measuring devices used for determining weight by measuring quantity of milk in farm tanks shall be done in accordance with the requirements of OAR chapter 603, division 027, to effectuate the administration of ORS Chapter 618.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 651 & 621
Stats. Implemented:
Hist.: DOA 6-2002, f. & cert. ef. 1-28-02; DOA 8-2006, f. & cert. ef. 3-10-06; DOA 6-2013, f. & cert. ef. 4-26-13; DOA 7-2015, f. & cert. ef. 4-3-15; DOA 13-2016, f. & cert. ef. 6-20-16

603-024-0041
Standard for Grade A Raw Goat Milk

(1) "Grade A Raw Goat Milk" is fluid milk bottled on a dairy farm and must be produced by a disease-free herd in conformance with all of the sanitation specified in OAR 603-024-0605 to 603-024-0641, and 603-024-0211.

(2) As determined in accordance with OAR 603-024-0557 to 603-024-0594 for each sampling period, Raw Goat Milk may not exceed:

(a) 80,000 bacteria count per milliliter;

(b) 10 coliform per milliliter;

(c) Cooling requirements covered in OAR 603-024-0211;

(d) The somatic cell limit in OAR 603-024-0592.

(3) Grade A Raw Goat milk must test negative for drug residue.

Stat. Auth.: ORS 651 & 621
Stats. Implemented:
Hist.: DOA 6-2002, f. & cert. ef. 1-28-02; DOA 6-2013, f. & cert. ef. 4-26-13; DOA 13-2016, f. & cert. ef. 6-20-16

603-024-0211
Adoption of the Grade A Pasteurized Milk Ordinance (PMO) and Related Documents

On all dairy farms, plants, and transport tankers, the standards for building construction, equipment construction, sanitation, sampling, pasteurization, transportation and handling of milk and dairy products shall be those given in the Grade "A" Pasteurized Milk Ordinance (PMO), 2015 Revision. This adoption shall also include the following related documents:

(1) 2015 Revision of the Methods of Making Sanitation Ratings (MMSR);

(2) 2015 Revision of Procedures Governing the Cooperative State-Public Health Service/Food and Drug Administration Program of the Conference on Interstate Milk Shipments; and

(3) The 2015 Revision of the Evaluation of Milk Laboratories (EML).

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 561.020 & 621
Stats. Implemented: 621.058
Hist.: DOA 6-2002, f. & cert. ef. 1-28-02; DOA 8-2006, f. & cert. ef. 3-10-06; DOA 9-2012, f. & cert. ef. 5-15-12; DOA 6-2013, f. & cert. ef. 4-26-13; DOA 7-2015, f. & cert. ef. 4-3-15; DOA 13-2016, f. & cert. ef. 6-20-16

603-024-0594
Drug Residue Test

(1) Antibiotic tests on each producer's milk or on commingled raw milk shall be conducted at least four times during any consecutive six months. When commingled milk is tested, all producers shall be represented in the samples. All individual sources of milk shall be tested when test results on the commingled milk are positive.

(2) Violation of drug residue test shall be cause for immediate embargo of all milk testing positive for drug residues that has not already been destroyed, consistent with the provisions of ORS 561.605–630. Additional milk produced after an embargo, if not immediately destroyed, shall be further until a representative sample taken from the producer's milk, prior to commingling with any other milk, is no longer positive for drug residue. This action shall not prevent the initiation of other enforcement actions as are available and necessary. If the milk testing positive for drug residues is destroyed prior to embargo, the distributor, producer-distributor, screening laboratory or certified laboratory must immediately notify the department and the producer must explain how the milk was destroyed. In addition to the requirements in ORS 561.305(3), a notice of embargo shall contain notice that another drug residue violation committed within six months of the embargo will be grounds for immediate suspension of a grade designation. The notice of embargo shall constitute a written notice for the purposes of ORS 621.073(3).

(a) Suspension of Grade Designation. If within six months of receiving a notice of embargo, an additional drug residue is detected, the Department may immediately suspend a producer's grade designation. Such notice of suspension is subject to review in the manner provided by ORS 183.484.

(3) After a third violation in a twelve month period, the Department shall initiate proceedings to revoke the producer's Grade "A" license pursuant to ORS 183.

Stat. Auth.: ORS 561.190, 621.060 & 621.261
Stats. Implemented: ORS 621.060 & 621.261
Hist.: AD 883(13-68), f. & ef. 7-1-68; AD 1044(34-74), f. 9-5-74, ef. 10-1-74; Renumbered from 603-024-0640.5; DOA 6-2002, f. & cert. ef. 1-28-02; DOA 13-2016, f. & cert. ef. 6-20-16

603-024-0641
Transportation of Milk and Milk Products and Surroundings

All producer Grade A raw milk for pasteurization must be picked up at least once each 72 hour period. In addition, to facilitate cleaning of the farm bulk tank, the tank shall be completely emptied once each 72 hour period.

Stat. Auth.: ORS 561 & 621
Stats. Implemented: ORS 621.060 & 621.261
Hist.: AD 883(13-68), f. & ef. 7-1-68; Renumbered from 603-024-0656.20; AD 9-1983, f. & ef. 8-22-83; DOA 6-2002, f. & cert. ef. 1-28-02; DOA 13-2016, f. & cert. ef. 6-20-16

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Rule Caption: Rule requires aerial application licensing certification for persons that want to aerially apply pesticides.
Adm. Order No.: DOA 14-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-28-16
Notice Publication Date: 5-1-2016
Rules Adopted: 603-057-0108
Subject: These rules are a result of House Bill 3549, which passed through the Oregon Legislature last year, was signed by the Governor, and subsequently codified in Oregon Revised Statutes at ORS 634.128. The rules state that individuals may not spray or otherwise apply a pesticide by aircraft unless the individual holds a valid aerial pesticide applicator certificate issued by the Oregon Department of Agriculture. A certificate is a license, and certain conditions must be met to qualify for the certificate. An applicant must have at least 50 hours of experience on flights conducted for the purpose of carrying out, or training to carry out, spraying or otherwise applying pesticides by aircraft.

The proposed rules also have conditions that will not be in effect until January 1, 2017. These conditions will require all aerial pesticide applicators to take and pass an examination approved by ODA. The test will

evaluate the knowledge of the individual regarding proper application of pesticides, which will include spraying. Furthermore, as House Bill 3549 states, aerial applicator certificate holders must complete a

mini mum of 10 credit hours of ODA approved instruction or educational courses related to the spraying and application of pesticides by aircraft during each five year certification period.
Rules Coordinator: Sue Gooch—(503) 986-4583

603-057-0108
Aerial Applications Generally

(1) A person may not spray or otherwise apply a pesticide by aircraft unless the person is an individual that holds a valid aerial pesticide applicator certificate issued by the Oregon Department of Agriculture.

Aerial Pesticide Applicator

(2) An aerial pesticide applicator certificate is a type of license.

(3) For 2016, an aerial pesticide applicator certificate may only be issued to an individual upon receipt and approval by the department of:

(a) An appropriately completed license application form;

(b) Payment of the appropriate fee;

(c) Proof that the individual holds a valid commercial pilot certificate for the type of aircraft to be used by the aerial pesticide applicator in applying pesticides;

(d) Proof that the individual holds a valid pesticide applicator, public applicator, or private applicator license or certificate; and

(e) Proof, in the form of a sworn statement or a declaration that the individual has either:

(A) At least fifty (50) hours of experience as a licensed pesticide applicator, licensed public applicator or certified licensed private applicator on flights conducted for the purpose of carrying out spraying or otherwise applying pesticides by aircraft; or

(B) At least fifty (50) hours of flight training experience as a licensed pesticide applicator, licensed public applicator, or certified private applicator, or as a pesticide trainee or public trainee under the supervision of a licensed pesticide applicator, licensed public applicator, or certified licensed private applicator, on flights conducted for the purpose of carrying out, or training to carry out, spraying or otherwise applying pesticides by aircraft.

(4) The department shall suspend or revoke the aerial pesticide applicator certificate if the certificate holder fails to maintain the valid pesticide applicator license, public applicator license or private applicator certificate that was the basis of obtaining the aerial pesticide applicator certificate.

(5) The annual fee for an aerial pesticide applicator certificate shall be the same as the fee for pesticide applicators.

(6) The certification period for an aerial pesticide applicator certificate issued for 2016 will expire on December 31, 2016.

(7) As of January 1, 2017, the certification period for an aerial pesticide applicator certificate shall not exceed five years.

(8) Beginning January 1, 2017, an aerial pesticide applicator certificate may only be issued to an individual upon receipt and approval by the department of:

(a) An appropriately completed license application form;

(b) Payment of the appropriate fee;

(c) Proof that the individual holds a valid commercial pilot certificate for the type of aircraft to be used by the aerial pesticide applicator in applying pesticides;

(d) Proof that the individual holds a valid pesticide applicator, public applicator, or private applicator license or certificate;

(e) Proof, in the form of a sworn statement or a declaration that the individual has either:

(A) At least fifty (50) hours of experience as a licensed pesticide applicator, licensed public applicator or certified licensed private applicator on flights conducted for the purpose of carrying out spraying or otherwise applying pesticides by aircraft; or

(B) At least fifty (50) hours of flight training experience as a licensed pesticide applicator, licensed public applicator or certified licensed private applicator, or as a pesticide trainee or public trainee under the supervision of a certified aerial pesticide applicator, on flights conducted for the purpose of carrying out, or training to carry out, spraying or otherwise applying pesticides by aircraft; and

(f) Proof that the individual has passed a national examination, or other examination approved by the department, testing the knowledge of the individual regarding proper spraying and other application of pesticides by aircraft.

(9) An applicant for an aerial pesticide applicator certificate issued under OAR 603-057-0108 (7) shall be required to take a re-examination each fifth year after taking the original aerial pesticide applicator examination.

(10) If the department's records indicate that an applicant for certificate renewal has successfully completed during the preceding five years at least 10 credit hours in programs of instruction or educational courses satisfactory to the department and related to the spraying or other application of pesticides by aircraft:

(a) The department shall count any credit hours in satisfactory programs of instruction or educational courses as described above toward any instruction or education requirements imposed by the department for the issuance or renewal of a pesticide applicator or public pesticide applicator license.

(b) The department may not count any credit hours in satisfactory programs of instruction or educational courses described above toward any instruction or education requirements imposed by the department for the issuance or renewal of a private applicator's license.

(11) As of January 1, 2017, and for an individual, the certification period of their pesticide applicator, public applicator or private applicator license may be aligned with the certification period for their aerial pesticide applicator certificate.

(12) An aerial pesticide applicator that was certificated solely on the basis of a public applicator license shall not spray or otherwise apply pesticides by aircraft to any lands beyond those lands that he is authorized to spray or otherwise apply pesticides to from the ground.

(13) In order to be authorized to make aerial pesticide applications, a pesticide applicator that is also certificated as an aerial pesticide applicator, must be employed by a pesticide operator with an aerial endorsement or other similar specification assigned by the department.

Stat. Auth.: ORS 634.106, 634.112, 634.116, 634.122 & 634.126
Stats. Implemented: ORS 634.128
Hist.: DOA 14-2016, f. & cert. ef. 6-28-16

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Rule Caption: Update and implement new fees for fertilizer rules.
Adm. Order No.: DOA 15-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 10-1-2015
Rules Adopted: 603-059-0060

Rules Amended: 603-059-0020, 603-059-0030, 603-059-0050, 603-059-0055, 603-059-0070, 603-059-0080
Subject: The rules effectuate the implementation of fertilizer, soil amendment, lime, and compost product registration fees increase, an inspection fee on lime, product evaluation fee increase, and update the rules to conform with the American Association of Plant Food Control Officials, Publication #68 developed under ORS 633.311 through 633.479 and OAR Chapter 603, Division 59.
Rules Coordinator: Sue Gooch—(503) 986-4583

603-059-0020
Inspection Fees

(1) The inspection fees authorized to be established by ORS 633 and payable under ORS 633 are as follows:

(a) Forty five cents ($0.45) for each ton of fertilizer;

(b) Forty five cents ($0.45) for each ton of agricultural mineral;

(c) Forty five cents ($0.45) for each ton of agricultural amendment;

(d) Five cents ($0.05) for each ton of fertilizer, agricultural mineral, or agricultural amendment containing 100% "compost" as defined in ORS 633.311.

(e) Five cents ($0.05) for each ton of gypsum.

(f) Five cents ($0.05) for each ton of lime.

(2) Any person required to pay inspection fees established in ORS 633 that distributes less than 33.34 tons of fertilizer, agricultural mineral or agricultural amendment products or less than 300 tons of lime, gypsum or compost products in any semi-annual reporting period, must pay a minimum inspection fee of fifteen dollars ($15.00).

(3) A portion of the inspection fees paid to the department for fertilizer, agricultural minerals and agricultural amendments shall be continuously appropriated for the purpose of funding grants for research and development related to the interaction of fertilizer, agricultural mineral or agricultural amendment products and ground water or surface water as described in ORS 633. The portion of fees so appropriated shall be determined by the Department based on the recommendation of the Fertilizer Research Committee (ORS 633.479).

(4) The inspection fees specified in section (1) of this rule shall be in effect commencing July 1, 2016.

Stat. Auth.: ORS 561.190 & 633 as amended by Ch. 514 OL 2015
Stats. Implemented: ORS 561.190 & 633
Hist.: AD 1071(17-75), f. & ef. 11-20-75; AD 10-1978, f. & ef. 7-10-78; AD 15-1983, f. 11-23-83, ef. 12-31-83; AD 14-1989, f. 10-12-89, cert. ef. 10-9-89; AD 1-1996, f. & cert. ef. 2-12-96; DOA 24-2001, f. & cert. ef. 10-15-01; DOA 12-2004, f. 4-15-04 cert. ef. 7-1-04; DOA 12-2012, f. 5-17-12, cert. ef. 1-1-13; DOA 15-2016, f. 6-30-16, cert. ef. 7-1-16

603-059-0030
Registration Fees

(1) The registration fee authorized to be established by ORS 633 for each fertilizer, agricultural mineral, agricultural amendment or lime product is as follows: Thirty Five dollars ($35.00) per year for each product registered;

(2) The registration fee specified in section (1) of this rule shall be in effect commencing July 1, 2016.

Stat. Auth.: ORS 561.190 & 633 as amended by Ch. 514 OL 2015
Stats. Implemented:
Hist.: DOA 24-2001, f. & cert. ef. 10-15-01; DOA 15-2016, f. 6-30-16, cert. ef. 7-1-16

603-059-0050
Evaluation Fee

(1) The product evaluation fee authorized to be established by ORS 633 is as follows:

(a) Up to five hundred dollars ($500.00) upon initial product registration;

(b) Up to five hundred dollars ($500.00) upon product reregistration or reevaluation of product registration.

(2) The fee specified in section (1) of this rule shall be in effect commencing July 1, 2016.

Stat. Auth.: ORS 561.190 & 633 as amended by Ch. 514 OL 2015
Stats. Implemented:
Hist.: DOA 24-2001, f. & cert. ef. 10-15-01; DOA 15-2016, f. 6-30-16, cert. ef. 7-1-16

603-059-0055
Labeling Requirements

(1) Any fertilizer, agricultural mineral, agricultural amendment or lime product distributed in this state must have the following information included as part of the product label required by ORS 633.321 to 633.341. At a minimum, one of the following labeling statements:

(a) "Information regarding the contents and levels of metals in this product is available on the internet at http://www.regulatory-info-xx.com". Each registrant must substitute a unique alpha numeric identifier for "xx". This statement may be used only if the registrant establishes and maintains the internet site and the internet site meets the following criteria:

(A) There is no advertising or company-specific information on the site:

(B) There is a clearly visible, direct hyperlink to the department's internet site specified in (b) of this subsection (1); and

(C) Any other criteria adopted by the director by rule.

(b) "Information regarding the contents and levels of metals in this product is available at the Oregon Dept of Agriculture internet site: http://oda.state.or.us/fertilizer"

(c) "Information regarding the contents and levels of metals in this product is available on the internet at..." The Association of American Plant Food Control Officials' hosted website developed to provide a uniform label internet address to access product content information is to be inserted to complete the above sentence. This specific address is the only AAPFCO web address that will be allowed for this product labeling purpose.

(2) At a minimum, the following product information will be maintained by the Department on the internet:

(a) Product name including brand name;

(b) Registrant name;

(c) Guaranteed primary, secondary and micronutrients;

(d) Lime Score for lime products;

(e) Levels of arsenic, cadmium, lead, mercury, and nickel; and

(f) State registration status.

(3) Any fertilizer, agricultural mineral, agricultural amendment, or lime product sold, offered for sale, or distributed in this state must be labeled in accordance to 603-059-0055(1).

(4) Failure to label a fertilizer, agricultural mineral, agricultural amendment, or lime product pursuant to 603-059-0055(1) which is sold, offered for sale, or distributed in this state shall be considered mislabeled. Mislabeling of any fertilizer, agricultural mineral, agricultural amendment or lime product in this manner is a violation of ORS 633.366(1)(a) as a Category III violation.

(5) Registrants of products that contain live microorganism(s) as active ingredients shall provide proof of the taxonomic identity of the organism(s) to the genus and species level and provide strain when known. Microorganisms that are listed as Risk Group Level 2 by the American Biological Safety Association (ABSA) on at least 3 of 9 reporting agencies or Biosafety Level 2 as defined by the American Type Culture Collection (ATCC) shall include the following precautionary statement on the label unless the department determines that the registrant provided sufficient safety information to waive the requirement or elements specified therein: "This product contains live microorganisms and may cause adverse effects to persons with a compromised immune system. Avoid contact with eyes, mouth, and broken skin. Do not inhale product. Wear eye and skin protection when handling. Wash hands after using."

Stat. Auth: ORS 561.190 & 633 as amended by Ch. 514 OL 2015
Stats. Implemented: ORS 633 as amended by Ch. 514 OL 2015
Hist.: DOA 24-2002, f. 12-2-02, cert. ef. 1-1-03; DOA 15-2016, f. 6-30-16, cert. ef. 7-1-16

603-059-0060
Definition of Labeling Terms

(1) For labels and labeling, the State Department of Agriculture uses the following definitions:

(a) Organic. Organic materials are the remains, residues, or waste products of any organism, have a carbon base, are 100% natural, and are allowed as inputs in organic crop production under the USDA National Organic Program. If mixed with synthetic materials, such as processing aids for extraction, stabilization, or isolation, the combined material is no longer considered organic. An example of an organic material would be ground kelp meal to which nothing has been added. An example of a non-organic material would be kelp extract, processed with potassium hydroxide, as the added potassium hydroxide is not an organic material.

(b) Natural. Natural materials exist in nature and have been altered from their original structure only by physical manipulation (e.g. ground, screened, or pelletized), and may or may not have a carbon base. Natural materials are allowed as inputs in organic crop production under the USDA National Organic Program and must not be mixed with synthetic materials. Examples of non-carbon based natural materials would be mined limestone and mined potassium sulfate, to which nothing has been added.

(c) Organic-based. Organic-based materials are a mixed product in which more than half of the materials are organic. If it is an organic-based fertilizer, more than half of the sum of the guaranteed primary nutrient percentages must be derived from organic materials. If it is an organic-based agricultural mineral, more than half of the sum of the guaranteed nutrient

percentages must be derived from organic materials. If it is an agricultural amendment, more than half of the total materials (by weight) must be derived from organic materials.

(d) Natural-based. Natural-based materials are a mixed product in which more than half of the materials are natural. If it is a natural-based fertilizer, more than half of the sum of the guaranteed primary nutrient percentages must be derived from natural materials. If it is a natural-based agricultural mineral, more than half of the sum of the guaranteed nutrient percentages must be derived from natural materials. If it is an agricultural amendment, more than half of the total materials (by weight) must be derived from natural materials.

(e) Natural and Organic. Products containing both natural and organic ingredients may be listed as "natural and organic." Product labels may list the proportions of these materials, i.e., "95% organic." As an example a product made of 30% blood meal, 20% bone meal, 20% kelp meal, and 30% greensand could be described as "70% organic."

(f) Organic Input. A product in which all ingredients comply with the requirements for producing organic agricultural products under the USDA National Organic Program Final Rule, 7 CFR Part 205.

(g) Synthetic. A substance that is formulated or manufactured by a chemical process or by a process that chemically changes a substance extracted from naturally occurring plant, animal, or mineral sources, except that such term shall not apply to substances created by naturally occurring biological processes.

(h) Biotic or Bioactive. A product with a guaranteed content of microbiological inoculum.

(i) No Phosphate Fertilizer. Fertilizer products with less than 0.5% available phosphate (P2O5). This definition also applies to other acceptable phrases used as descriptors which include, but are not limited to, "phosphate free" and "phosphorus free".

(j) Low Phosphate Fertilizer. Fertilizer products with available phosphate levels (P2O5) equal to, or greater than, 0.5%, but less than 1%.

(k) Non-toxic. Materials incapable of causing harmful effects to living organisms. As determined by the department, the claim must be adequately substantiated by supporting data.

Stat. Auth: ORS 561.190 & ORS 633 as amended by Ch. 514 OL 2015
Stats.Implemented: ORS 633 as amended by Ch. 514 OL Stats
Hist.: DOA 15-2016, f. 6-30-16, cert. ef. 7-1-16

603-059-0070
Investigational Allowances, Minimum Detection Limits

(1) Investigational allowance means an allowance for variations inherent in the taking, preparation and analysis of an official sample. The following investigational allowances provide enforcement consistency in determining deficiencies in products addressed in the administration of ORS 633.311 to 633.479 and 633.994. Products will be deemed deficient if the analysis is below the guarantee by an amount exceeding the following values:

(a) Investigational allowances for primary nutrients are as follows:

% Guarantee — N — P2O5 — K2O
4% or Less — 0.49 — 0.67 — 0.41;
5% — 0.51 — 0.67 — 0.43;
6% — 0.52 — 0.67 — 0.47;
7% — 0.54 — 0.68 — 0.53;
8% — 0.55 — 0.68 — 0.60;
9% — 0.57 — 0.68 — 0.65;
10% — 0.58 — 0.69 — 0.70;
12% — 0.61 — 0.69 — 0.79;
14% — 0.63 — 0.70 — 0.87;
16% — 0.67 — 0.70 — 0.94;
18% — 0.70 — 0.71 — 1.01;
20% — 0.73 — 0.72 — 1.08;
22% — 0.75 — 0.72 — 1.15;
24% — 0.78 — 0.73 — 1.21;
26% — 0.81 — 0.73 — 1.27;
28% — 0.83 — 0.74 — 1.33;
30% — 0.86 — 0.75 — 1.39;
32% — 0.88 — 0.76 — 1.44;
34% — * — 0.79 — 1.46;
36% — * — 0.83 — 1.49;
38% — * — 0.86 — 1.51;
40% — * — 0.90 — 1.54;
42% — * — 0.93 — 1.56;
44% — * — 0.96 — 1.58;
46% — * — 1.00 — 1.46;
48% — * — 1.03 — 1.63;
50% — * — 1.07 — 1.66;
52% — * — 1.10 — 1.68;
54% — * — # — 1.70;
56% — * — # — 1.73;
58% — * — # — 1.75;
60% — * — # — 1.78;
62% — * — # — 1.80.

* For N guarantees above 32%, the investigational allowance shall be 0.88.
# For P2O5 guarantees above 52%, the investigational allowance shall be 1.10.
For K2O guarantees above 62%, the investigational allowance shall be 1.80.
For guarantees not listed, calculate the appropriate value by interpolation.

(b) Investigational allowances for secondary nutrients and micronutrients are as follows:

Element -- Investigational Allowance
Ca — 0.2 Unit + 5% of Guarantee;
Mg — 0.2 Unit + 5% of Guarantee;
S — 0.2 Unit + 5% of Guarantee;
B — 0.003 Unit + 15% of Guarantee;
Co — 0.0001 Unit + 30% of Guarantee;
Cl — 0.005 Unit + 10% of Guarantee;
Cu — 0.005 Unit + 10% of Guarantee;
Fe — 0.005 Unit + 10% of Guarantee;
Mn — 0.005 Unit + 10% of Guarantee;
Mo — 0.0001 Unit + 30% of Guarantee;
Na — 0.005 Unit + 10% of Guarantee;
Zn — 0.005 Unit + 10% of Guarantee.
"UNIT" is twenty (20) pounds of plant food or one percent (1%) of a ton
The maximum allowance when calculated in accordance to the above shall be 1 unit (1%).

(c) Investigational allowances for lime products are as follows:

(A) When the Lime Score is found to be more than 5% deficient from the stated Lime Score.

(B) When the amount of calcium carbonate, calcium oxide, magnesium carbonate or magnesium oxide content is found to be more than 10% below the guarantee.

(d) Investigational allowances for ingredients other than primary nutrients, secondary nutrients and micronutrients are as follows:

(A) When the amount of other ingredients is found to be more than 15% below the guarantee.

(2) Minimum detection limits for laboratory analysis reports of metal levels required by the department in accordance with ORS 633.362 must be declared at, or below, the following:

Arsenic — 10.0 ppm;
Cadmium — 05.0 ppm;
Lead — 05.0 ppm;
Mercury — 0.20 ppm;
Nickel — 05.0 ppm.
Stat. Auth: ORS 561.190 & 633 as amended by Ch. 514 OL 2015
Stats. Implemented: ORS 633 as amended by Ch. 514 OL 2015
Hist.: DOA 24-2002, f. 12-2-02, cert. ef. 1-1-03; DOA 15-2016, f. 6-30-16, cert. ef. 7-1-16

603-059-0080
Enforcement Guidelines

(1) In addition to any other penalty provided by law, the Director may assess civil penalties for prohibited acts identified in ORS 633.366. Civil penalties will be issued in accordance to the magnitude of the violation. The department is not precluded from utilizing other enforcement alternatives. Enforcement alternatives may include, but are not limited to, letter of advisement, notice of violation, stop sale, use or removal order, and license/registration revocation, suspension or denial. Commission of each prohibited act is a violation of ORS Chapter 633 and subject to a civil penalty. Prohibited acts are categorized as to the magnitude of violation as follows:

(a) Category I (Major): The Department will issue a civil penalty for initial Category I violations in addition to any alternative enforcement action deemed necessary to protect the public interests. Category I violations include:

(A) ORS 633.366(1)(b) Register or attempt to register any product using fraudulent or deceptive practices to evade or attempt to evade the requirements of ORS 633.311 to 633.479 and 633.994 or rules adopted thereunder;

(B) ORS 633.366(1)(g) Make false or fraudulent applications, records, invoices or reports;

(C) ORS 633.366(1)(j) Sell, use or remove any product subjected to a stop sale, use or removal order until the product has been released in accordance with ORS 633.445;

(D) ORS 633.366(1)(k) Impede, obstruct, hinder or otherwise prevent or attempt to prevent the department from the performance of department duties under ORS 633.311 to 633.479 and 633.994.;

(b) Category II (Moderate): The Department may take initial alternative enforcement action and may allow a specified amount of time to take corrective action prior to issuance of a civil penalty for a Category II violation. Failure to complete the required corrective action within the specified time period, or repeat violations, will result in the immediate issuance of a civil penalty. Category II violations include:

(A) Sell, offer for sale, or distribute adulterated products (ORS 633.366(1)(c));

(B) Fail, refuse, or neglect to keep or maintain records as required under ORS 633.476, Chapter 514, Oregon Laws 2015, section 2 and sec-

tion 3 or refuse to make available such records pursuant to ORS 633.385 upon request by the department (ORS 633.366(1)(f));

(C) Knowingly or intentionally make any false or misleading representations in connection with the sale, offer for sale, or distribution of fertilizer, agricultural amendment, agricultural mineral, or lime products (ORS 633.366(1)(L)).

(c) Category III (Minor): The Department will take initial alternative enforcement action in writing and will allow a specified amount of time to take corrective action prior to the issuance of a civil penalty for a Category III violation. Failure to complete the corrective action within the specified time period, or repeat violations, may result in the immediate issuance of a civil penalty. Category III violations include:

(A) Sell, offer for sale, or distribute mislabeled products (ORS 633.366(1)(a)), including, but not limited to, when the product is:

(i) Deemed deficient as defined in 603-059-0070(1)(a)–(d);

(ii) Not labeled pursuant to 603-059-0055(1) or 603-059-0055(5)

(B) Fail, refuse, or neglect to deliver to a purchaser of a bulk fertilizer, agricultural amendment, agricultural mineral or lime product a printed label that complies with ORS 633.321 to 633.341 (633.366(1)(d));

(C) Sell, offer for sale, or distribute a fertilizer, agricultural amendment, agricultural mineral or lime product that is not registered with the State Department of Agriculture under ORS 633.362 (633.366(1)(e));

(D) Fail, refuse, or neglect to provide notification to the department as required by ORS 633.318(5) or 633.362(8) (633.366(1)(h));

(E) Fail, refuse, or neglect to obtain a manufacturer-bulk distributor license required under ORS 633.318 (633.366(1)(i));

(F) Fail, refuse, or neglect to file a semiannual statement with the department as required under Chapter 514, Oregon Laws 2015, section 2 and section 3 (ORS 633.366(1)(m));

(G) Fail, refuse, or neglect to pay inspection fees required under Chapter 514, Oregon Laws 2015, section 3 (ORS 633.366(1)(n)).

(d) To "refuse", in the context of these prohibited acts, constitutes a willful misconduct violation and is subject to a civil penalty of not more than $10,000 for the initial violation or any subsequent violation.

(2) Maximum civil penalties are not to exceed the following:

Category — 1st Violation — 2nd Violation — 3rd+ Violation;
Category I (Major) — $500 — $1500 — $10,000;
Category II (Moderate) — $250 — $750 — $5000;
Category III (Minor) — $125 — $375 — $2500.

(3) As authorized by ORS 633.994(5) A civil penalty imposed under 633.311 to 633.479 and 633.994 may be remitted or reduced upon such terms and conditions as the Director of Agriculture considers proper and consistent with the public health and safety.

(4) As authorized by ORS 633.994(3), any violation that arises from gross negligence or willful misconduct and results in substantial harm to human health or the environment may be subject to a civil penalty of not more than $10,000 for the initial violation or any subsequent violation.

Stat. Auth: ORS 561.190 & 633 as amended by Ch. 514 OL 2015
Stats. Implemented: ORS 633 as amended by Ch. 514 OL 2015
Hist.: DOA 24-2002, f. 12-2-02, cert. ef. 1-1-03; DOA 15-2016, f. 6-30-16, cert. ef. 7-1-16

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

Rule Caption: Uniform Alternate Construction Standards
Adm. Order No.: BCD 7-2016(Temp)
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-28-16 thru 12-24-16
Notice Publication Date:
Rules Adopted: 918-480-0125
Rules Suspended: 918-480-0100, 918-480-0110, 918-480-0120
Subject: This rule allows a building official to utilize uniform alternate construction standards when fire apparatus means of approach or water supply are inadequate as determined in accordance with ORS 455.610.
Rules Coordinator: Holly A. Tucker—(503) 378-5331

918-480-0100
Purpose and Scope

(1) The building official may allow an alternate to the minimum requirements of **Oregon Residential Specialty Code** as authorized by ORS 455.610, which may include, but is not limited to, installation of an automatic fire sprinkler system, where it is determined the fire apparatus means of approach to a property or the fire fighting water supply serving a property, does not meet the local standards adopted in accordance with the applicable fire code and state building code requirements. The rule applies only to dwellings and habitable rooms within accessory structures built under the **Oregon Residential Specialty Code** unless otherwise stated in the land use approvals for accessory structures built under this code.

(2) These rules are not intended to automatically require construction elements that are not otherwise required by the **Oregon Residential Specialty Code**.

(3) A request for an alternate under these rules may be approved only where the property is included in an area:

(a) Where there is an established and recognized provider of fire protection services; and

(b) Where there are local standards adopted in accordance with applicable fire code and state building code requirements identified for fire fighting water supply or fire apparatus access roads that include any or all of the following: public access roads, shared private access roads and private driveways.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 455.610
Stats. Implemented: ORS 455.610
Hist.: BCD 20-2002, f. 8-1-02, cert. ef. 10-1-02; BCD 13-2011, f. 5-13-11, cert. ef. 7-1-11; Suspended by BCD 7-2016(Temp), f. & cert. ef. 6-28-16 thru 12-24-16

918-480-0110
Definitions

For the purpose of these rules:

(1) "Fire Apparatus Means of Approach" may include a public access road, a shared private access road or a private driveway.

(2) "Private Driveway" means a private road giving fire apparatus access from a public access road or shared private access road to a building or buildings on a single property.

Stat. Auth.: ORS 455.610
Stats. Implemented: ORS 455.610
Hist.: BCD 20-2002, f. 8-1-02, cert. ef. 10-1-02; BCD 13-2011, f. 5-13-11, cert. ef. 7-1-11; Suspended by BCD 7-2016(Temp), f. & cert. ef. 6-28-16 thru 12-24-16

918-480-0120
Approval of an Alternate Method of Construction

The building official must ensure the following criteria have been met when allowing the use of an approved alternate method of fire protection under the scope of these rules:

(1) The alternate must be at the request of the applicant;

(2) For lots of record created on or after January 1, 2002, the building official must confirm the fire official having authority has, in accordance with the adopted fire code:

(a) Approved the alternate to adopted fire apparatus access road, private driveway or fire fighting water supply standards during the land use approval process; and

(b) The approved alternate has been recorded on the property deed as a requirement for future construction.

(3) For lots of record created before January 1, 2002, the building official must, prior to authorizing an alternate allowing the development of a parcel that could not otherwise be developed because it cannot meet adopted fire access road, private driveway or fire fighting water supply standards, consult with the fire official having authority to approve an alternate to fire access and water supply standards under the adopted fire code;

(4) Providing the requirements of this rule are met, the local building official is authorized to enforce the conditions of an approved alternate method of construction when it is part of the building construction; and

(5) When the approved alternate is a fire sprinkler system, the minimum standard for installation within one- and two-family dwellings must be the **NFPA 13-D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes** as adopted by reference in the **Oregon Residential Specialty Code**.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 455.610
Stats. Implemented: ORS 455.610
Hist.: BCD 20-2002, f. 8-1-02, cert. ef. 10-1-02; BCD 13-2011, f. 5-13-11, cert. ef. 7-1-11; Suspended by BCD 7-2016(Temp), f. & cert. ef. 6-28-16 thru 12-24-16

918-480-0125
Uniform Alternate Construction Standard

(1) For lots of record created on or after January 1, 2002, if the building official intends to allow one or more of the Uniform Alternate Construction Standards at the time of building permit application, triggered by fire official determinations of inadequate apparatus access or water supply, the building official must:

(a) Provide at least a general notification of the intent to allow such Uniform Alternate Construction Standards; and

(b) Provide such notification in conjunction with the approval of a land use application under ORS 197.522.

(2) The building official, acting in conformance with these rules, may choose to apply one or more Uniform Alternate Construction Standards to address determinations by fire officials with authority over water supply and apparatus access, that the water supply, apparatus access, or both are inadequate at a site. Such decisions by the building official are final. A building official shall give consideration to advice of the State Fire Marshal or local fire official that does not conflict with this rule, but shall retain the authority to make final decisions.

(3) A Uniform Alternate Construction Standard is not a Statewide Alternate Method.

(4) Uniform Alternate Construction Standards. Uniform Alternate Construction Standard determinations shall be made by the building official. Uniform Alternate Construction Standards are limited to one or more of the following fire suppression and fire containment components:

(a) Installation of a NFPA Standard 13D fire suppression system;

(b) Installation of a partial NFPA Standard 13D fire suppression system;

(c) Installation of additional layers of 5/8 inch, Type-X gypsum wallboard;

(d) Installation of fire-resistive compartmentalization of dwellings to limit the spread of fire by use of fire-resistant building elements, components or assemblies. Fire-resistance ratings shall be determined in accordance with the Oregon Structural Specialty Code;

(e) Installation of fire-resistive exterior wall covering and roofing components; or

(f) Provide fire separation containment in accordance with the default standards as set forth in the Wildland-Urban Interface rules adopted by the Oregon Department of Forestry (see OAR 629-044-1060).

Stat. Auth.: ORS 455.610
Stat. Implemented: ORS 455.610
Hist.: BCD 7-2016(Temp), f. & cert. ef. 6-28-16 thru 12-24-16

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Rule Caption: Amending certification requirements for building officials, inspectors and plans examiners.
Adm. Order No.: BCD 8-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Adopted: 918-098-1100, 918-098-1475
Rules Amended: 918-098-1010, 918-098-1012, 918-098-1015, 918-098-1025, 918-098-1028
Subject: These rules amend the division's certification requirements and obligations for building officials, inspectors and plans examiners. The rules contain a variety of changes, including, but not limited to: clarifying experience requirements for Oregon Code Certification applicants, creating a transition from International Code Council or other nationally recognized certifications to equivalent Oregon certifications, expanding the scope of work for residential structural inspectors to include mechanical work, clarifying the renewal process for OIC holders, removing the 5-year OIC reinstatement window for OIC holders, clarifying continuing education requirements for certification holders, and clarifying conflict of interest requirements for certification holders.
Rules Coordinator: Holly A. Tucker—(503) 378-5331

918-098-1010
Certification Requirements

(1) Plan review certification is not required for individuals reviewing one- and two-family dwelling permit applications for the following:

(a) First floor decks attached to a dwelling that:

(A) Extend not more than 12 feet from the dwelling but not closer than three feet to a property line;

(B) Are not more than 8 feet above grade;

(C) Will not exceed a 70 PSF live load and not a combined live and dead load of 80 PSF; and

(D) Are not in excess of a 2 horizontal 1 vertical ground slope.

(b) Car ports with a single slope that:

(A) Have a rafter span extending not more than 12 feet from a dwelling;

(B) Are attached to the dwelling for the full length not to exceed 30 feet;

(C) Have a maximum overhang of two feet that is not closer than three feet to a property line; and

(D) Will not exceed a combined 80 PSF live and dead load.

(c) Patio covers that:

(A) Have a single slope roof;

(B) Have a rafter span extending not more than 12 feet from the dwelling;

(C) Are attached to the dwelling the full length not to exceed 30 feet;

(D) Have a maximum overhang of two feet that is not closer than three feet to a property line; and

(E) Will not exceed a combined 80 PSF live and dead load.

(d) Fences not greater than 8 feet in height.

(e) Garage conversions as an accessory to a one- or two-family dwelling with no new cut openings in the existing wall.

(f) Window, door, or bathroom remodels where there are no load-bearing or lateral-bracing wall penetrations.

(g) Pole or manufactured steel structures with a maximum of 3,000 square feet that:

(A) Have a maximum 14-foot eave height;

(B) Are not closer than three feet to the property line and at least 6 feet from all other buildings on the same lot; and

(C) Fully engineered, including foundation where applicable.

(h) Mechanical equipment for the purposes of determining setback requirements have been met.

(2) Plan review certification is not required for individuals reviewing permit applications for buildings or structures that have plans and specifications provided by the department or a municipality under ORS 455.062.

(3) The building official is responsible for ensuring that persons performing permit reviews under this section utilize a division-approved checklist to perform reviews.

(4) The building official may determine based on unusual features, characteristics or other complicating circumstances that a certified individual must review a permit application.

(5) Where a jurisdiction routinely performs permit reviews for a type of project determined by the building official to be similar in complexity to the types of projects listed in sections (1) and (2) of this rule, the building official may submit a checklist to the division for approval. If approved, the jurisdiction may utilize the checklist in the same manner as section (3).

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 455.030, 455.055, 455.062, 455.110, 455.720, & 455.730
Stat. Implemented: ORS 455.030, 455.055, 455.062, 455.110, 455.720, & 455.730
Hist.: BCD 16-2005(Temp), f. & cert. ef. 7-7-05 thru 12-31-05; BCD 24-2005, f. 9-30-05, cert. ef. 10-1-05; BCD 4-2006, f. 3-31-06, cert. ef. 4-1-06; BCD 18-2006, f. 12-29-06, cert. ef. 1-1-07; BCD 6-2010, f. 5-14-10, cert. ef. 7-1-10; BCD 7-2011, f. & cert. ef. 3-11-11; BCD 24-2011, f. 7-26-11, cert. ef. 10-1-11; BCD 7-2013(Temp), f. 7-26-13, cert. ef. 8-1-13 thru 12-31-13; BCD 9-2013, f. 12-16-13, cert. ef. 1-1-14; BCD 5-2014, f. & cert. ef. 4-1-14; BCD 1-2016(Temp), f. & cert. ef. 1-26-16 thru 7-23-16; BCD 6-2016, f. & cert. ef. 4-1-16; BCD 8-2016, f. 6-30-16, cert. ef. 7-1-16

918-098-1012
Scope of Work Allowed for Persons with an Oregon Inspector Certification and a Nationally Recognized Certification

This rule is repealed effective November 1, 2016. After November 1, 2016, this rule will no longer be necessary because individuals may not perform inspections or plan reviews without an Oregon Code Certification. The scopes of work in this rule will be covered by OAR 918-098-1015. See also 918-098-1100 for information about transitioning nationally recognized certifications to Oregon Code Certifications.

(1) Individuals meeting the experience requirement in OAR 918-098-1025 who possess a valid Oregon Inspector Certification and a current International Code Council certification may perform work based on the type of International Code Council Certification they possess.

(2) A Certified Building Official Legal/ Management may oversee a jurisdiction's administration and enforcement of the state building code for those specialty codes assumed by the jurisdictions pursuant to ORS 455.148 or 455.150. Building officials may not perform plan reviews or inspections unless they possess the appropriate certification for the type of plan review or inspection being performed.

(a) Commercial Building Inspector certificate holders may conduct construction inspections for:

(A) All work regulated by the Oregon Structural Specialty Code; and

(B) Structural work on townhouse structures and apartment buildings regulated by the Oregon Residential Specialty Code.

(b) Commercial Building Plans Examiner certificate holders may review construction plans for:

(A) Compliance with the provisions of the Oregon Structural Specialty Code and Oregon Fire Code, except the fire and life safety plan

review provisions for structures required to receive a state fire and life safety plan review; and

(B) Fire and life safety construction on townhouse structures and apartment buildings regulated by the Oregon Residential Specialty Code.

(c) Commercial Fire Plans Examiner certificate holders who also have the Commercial Building Plans Examiner Certificate may review construction plans for compliance with the fire and life safety plan review provisions of the Oregon Structural Specialty Code and the Oregon Fire Code.

(d) A Commercial Mechanical Inspector certificate holder may conduct construction inspections and may review construction plans for:

(A) All work regulated by the Oregon Mechanical Specialty Code; and

(B) Mechanical work on townhouse structures and apartment buildings regulated by the Oregon Residential Specialty Code.

(e) A Residential Building Inspector certificate holder may conduct construction inspections and plan reviews for structural work regulated by the Oregon Residential Specialty Code; and

(A) Construction work on any aspect of manufactured structures and accessory buildings and structures regulated under the Oregon Manufactured Dwelling Installation Specialty Code;

(B) The provisions of OAR chapter 918, division 500;

(C) The Manufactured Home Construction and Safety Standards in 24 CFR 3280 and 24 CFR 3282; and

(D) Plan review and inspection of manufactured dwelling parks, recreational parks, organizational camps, and picnic parks.

(f) A Residential Mechanical Inspector certificate holder may conduct inspections and plan reviews for mechanical work regulated by the Oregon Residential Specialty Code; and

(A) Mechanical work on manufactured dwelling alterations under the Oregon Manufactured Dwelling Installation Specialty Code;

(B) The provisions of OAR chapter 918, division 500;

(C) The Manufactured Home Construction and Safety Standards located in 24 CFR 3280 and 3282; and

(D) Plan review and inspection of manufactured dwelling parks, recreational parks, organizational camps, and picnic parks.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 455.720 & 455.730

Stats. Implemented: ORS 455.720 & 455.730

Hist.: BCD 24-2005, f. 9-30-05, cert. ef. 10-1-05; BCD 4-2006, f. 3-31-06, cert. ef. 4-1-06; BCD 13-2007, f. 12-28-07 cert. ef. 1-1-08; BCD 1-2010, f. 3-1-10, cert. ef. 4-1-10; BCD 6-2016, f. & cert. ef. 4-1-16; BCD 8-2016, f. 6-30-16, cert. ef. 7-1-16

918-098-1015

Scope of Work Allowed for Persons with an Oregon Inspector Certification and Oregon Code Certifications

Persons who possess a valid Oregon Inspector Certification and a valid Oregon Code Certification may perform inspections and plan reviews based on the class designated on their certificate. The classes, other than electrical and plumbing inspector classifications found in OAR 918-281-0020 and 918-695-0400, are:

(1) Building Official. Persons certified as an Oregon Building Official may oversee jurisdictions' administration and enforcement of the state building code for those specialty codes assumed by the jurisdiction pursuant to ORS 455.148 or 455.150. Building officials may not perform plan reviews or inspections unless they possess the appropriate certification for the plan review or inspection being performed.

(2) Fire and Life Safety. Persons certified as fire and life safety plans examiners may review construction plans for compliance with the fire and life safety plan review provisions of the Oregon Structural Specialty Code and the Oregon Fire Code for any structure regulated by the Oregon Structural Specialty Code.

(3) A-Level.

(a) Persons certified as A-level structural plans examiners may:

(A) Review construction plans for compliance with the provisions of the Oregon Structural Specialty Code and Oregon Fire Code for all work regulated by the Oregon Structural Specialty Code, except the fire and life safety plan review provisions for structures required to receive a state fire and life safety plan review; and

(B) Review construction plans for work that falls within the B-level structural plans examiner classification.

(b) Persons certified as A-level structural inspectors:

(A) Conduct construction inspections of all work regulated by the Oregon Structural Specialty Code; and

(B) Conduct inspections of work that falls within the B-level structural inspector classification.

(c) Persons certified as A-level mechanical inspectors may:

(A) Conduct construction inspections and may review construction plans for all work regulated by the Oregon Mechanical Specialty Code; and

(B) Conduct inspections and review construction plans for work that falls within the B-level mechanical inspector classification.

(4) B-Level.

(a) Persons certified as B-level structural plans examiners may review construction plans for compliance with the provisions of the Oregon Structural Specialty Code and Oregon Fire Code for work regulated by the Oregon Structural Specialty Code, except:

(A) Work in structures required to receive a state fire and life safety plan review; and

(B) Work in structures required to be designed by an Oregon registered architect or certified professional engineer pursuant to ORS chapter 671.

(b) Persons certified as B-level structural inspectors may conduct construction inspections of work regulated by the Oregon Structural Specialty Code, except:

(A) Work in structures required to receive a state fire and life safety plan review; and

(B) Work in structures required to be designed by an Oregon registered architect or certified professional engineer pursuant to ORS chapter 671.

(c) Persons certified as B-level mechanical inspectors may conduct construction inspections of work regulated by the Oregon Mechanical Specialty Code, except:

(A) Work in structures required to receive a state fire and life safety plan review; and

(B) Work in structures required to be designed by an Oregon registered architect or certified professional engineer pursuant to ORS chapter 671.

(d) Persons certified as B-level structural plans examiners, B-level structural inspectors, or B-level mechanical inspectors:

(A) May qualify to be certified to review construction plans or conduct inspections of structures regulated by the Oregon Residential Specialty Code; and

(B) May not be authorized to review construction plans or conduct inspections of structures that are outside the B-level classification without first obtaining the appropriate certification.

(5) One and two family dwelling or residential.

(a) Persons certified as one and two family dwelling or residential:

(A) Structural inspectors may conduct construction inspections of structural and mechanical work regulated by the Oregon Residential Specialty Code; and

(i) Manufactured structures and manufactured structure accessory buildings and structures under the Oregon Manufactured Dwelling Installation Specialty Code;

(ii) The provisions of OAR chapter 918, division 500;

(iii) The Manufactured Home Construction and Safety Standards located in 24 CFR 3280 and 3282; and

(iv) Plan review and inspection of manufactured dwelling parks, recreational parks, organizational camps, and picnic parks.

(B) Mechanical inspectors may conduct inspections for mechanical work regulated by the Oregon Residential Specialty Code; and

(i) Manufactured dwellings under the Oregon Manufactured Dwelling Installation Specialty Code;

(ii) The provisions of OAR chapter 918, division 500;

(iii) The Manufactured Home Construction and Safety Standards located in 24 CFR 3280 and 3282; and

(iv) Plan review and inspection of manufactured dwelling parks, recreational parks, organizational camps, and picnic parks.

(C) Plumbing inspectors may conduct inspections for plumbing work regulated by the Oregon Residential Specialty Code; and

(i) Manufactured dwellings under the Oregon Manufactured Dwelling Installation Specialty Code;

(ii) The provisions of OAR chapter 918, division 500;

(iii) The Manufactured Home Construction and Safety Standards located in 24 CFR 3280 and 3282;

(iv) Plan review and inspection of manufactured dwelling parks, recreational parks, organizational camps, and picnic parks; and

(v) Any portion of a solar water heating system installation up to 180 gallons of storage tank capacity.

(D) Electrical inspectors may conduct inspections for electrical work regulated by the Oregon Residential Specialty Code; and

(i) The Oregon Manufactured Dwelling Installation Specialty Code;

(ii) The provisions of OAR chapter 918, division 500;

(iii) The Manufactured Home Construction and Safety Standards located in 24 CFR 3280 and 3282;

(iv) Plan review and inspection of manufactured dwelling parks, recreational parks, organizational camps, and picnic parks; and

(v) Any portion of a solar PV installation up to 25 Kw.

(b) Persons certified as a one-and-two family dwelling plans examiners may review construction plans for compliance with provisions of the Oregon Residential Specialty Code; and

(i) Structures under the Oregon Manufactured Dwelling Installation Specialty Code;

(ii) The provisions of OAR chapter 918, division 500;

(iii) The Manufactured Home Construction and Safety Standards located in 24 CFR 3280 and 3282; and

(iv) Plan review and inspection of manufactured dwelling parks, recreational parks, organizational camps, and picnic parks.

(c) Persons certified as a one and two family dwelling or residential inspectors and plans examiners may not be authorized to review construction plans or conduct inspections of either A-level or B-level structures without the required commercial A-level or B-level certification.

(d) See OAR 918-098-1325 for additional requirements of one and two family dwelling residential inspectors and plans examiners performing manufactured dwelling alteration inspections or plan reviews.

(e) See OAR 918-098-1330 for additional requirements of one and two family dwelling residential inspectors performing manufactured structure accessory structure or accessory building inspections.

(6) Specialized Solar Photo-Voltaic. Persons certified as a Specialized Solar PV inspector may conduct inspections of the structural and electrical systems for solar PV installations up to 25 Kw that follow the "prescriptive installation" provisions in section 3111.5 of the Oregon Structural Specialty Code.

(7) Plumbing inspectors certified under OAR 918-695-0400 may, in addition to any other authority, inspect any portion of a solar water heating system installation up to 180 gallons of storage tank capacity. This rule does not apply to limited or special plumbing inspectors.

(8) Electrical inspectors certified under OAR 918-281-0020 may, in addition to any other authority, inspect any portion of a solar PV installation up to 25 Kw.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 455.720

Stats. Implemented: ORS 455.720

Hist.: DC 24-1978, f. & ef. 9-1-78; DC 10-1980, f. & ef. 9-10-80; DC 4-1983, f. & ef. 1-12-83; Renumbered from 814-003-0065; BCA 16-1992, f. & cert. ef. 8-11-92; BCD 8-1997, f. & cert. ef. 4-1-97; Renumbered from 918-099-0065; BCD 15-1997, f. 9-30-97, cert. ef. 10-1-97; BCD 16-2005(Temp), f. & cert. ef. 7-7-05 thru 12-31-05, Renumbered from 918-098-0060; BCD 24-2005, f. 9-30-05, cert. ef. 10-1-05, Renumbered from 918-098-0060; BCD 4-2006, f. 3-31-06, cert. ef. 4-1-06; BCD 13-2007, f. 12-28-07 cert. ef. 1-1-08; BCD 1-2010, f. 3-1-10, cert. ef. 4-1-10; BCD 6-2010, f. 5-14-10, cert. ef. 7-1-10; BCD 7-2011, f. & cert. ef. 3-11-11; BCD 24-2011, f. 7-26-11, cert. ef. 10-1-11; BCD 5-2014, f. & cert. ef. 4-1-14; BCD 6-2016, f. & cert. ef. 4-1-16; BCD 8-2016, f. 6-30-16, cert. ef. 7-1-16

918-098-1025

Certification Requirements

(1) Unless otherwise stated in this rule, every person who performs building official duties, building code inspections, or plan reviews must possess a valid Oregon Inspector Certification and a valid appropriate Oregon Code Certification or authorization from the division for the work being performed.

(2)(a) Persons applying for the Oregon Inspector Certification must:

(A) Submit a division-approved application with the $125 fee; and

(B) Successfully pass the Oregon Inspector Certification examination.

(b) Applicants for an Oregon Inspector Certification who fail the examination may reapply under this section to retest for a fee of $80.

(3) Persons applying for an Oregon Code Certification under these rules, or under OAR 918-281-0020 and 918-695-0400 must:

(a) Submit a division-approved application demonstrating appropriate experience, if required for the certification by OAR chapter 918, division 281, 695, or these rules, or complete a certification training course administered by the division;

(b) Have a minimum level of experience as follows:

(A) Completion of a code certification training course administered by the division; or

(B) For an individual hired by a municipality, completion of a code certification training course administered by the division within six months of hire; or

(C) Two years experience working for or on behalf of a jurisdiction performing building permit inspections or plan reviews for buildings or structures regulated by the state building code or its equivalent; or

(D) Be a registered architect, a certified professional engineer, or have a Bachelor's or Master's degree in architecture or engineering.

(c) Pay the $80.00 fee; and

(d) Successfully pass the appropriate Oregon Code Certification exam, or submit proof of a valid appropriate International Code Council certification or other valid appropriate nationally recognized certification or license for:

(A) Commercial Building Inspector;

(B) Commercial Building Plans Examiner;

(C) Commercial Fire Plans Examiner;

(D) Commercial Mechanical Inspector;

(E) Residential Building Inspector;

(F) Residential Plans Examiner; and

(G) Any other International Code Council or other nationally recognized certification the division determines is equivalent to an Oregon Code Certification.

(4) Persons applying for a training course administered by the division must:

(a) Submit a division-approved registration form; and

(b) Pay the course registration fee.

(5) A person must successfully complete a division certification training course in order to obtain division certification through the course.

(6) Applicants for certification as a building official and certified Oregon building officials must possess a valid Oregon Inspector Certification and must enroll in or complete a certification training course for building officials administered by the division within six months of hire unless the person has previously completed a building official training course administered by the division. A person enrolled in a certification training course for building officials administered by the division must successfully complete this course to continue performing building official duties.

(7) Applicants for an Oregon Code Certification who fail the examination may reapply under section (3) of this rule to retest. Applicants may not retake the test for 30 days after each failed attempt.

(8) If an applicant fails to take the Oregon Inspector Certification exam or the Oregon Code Certification exam within 60 days of being approved to do so, the application is considered withdrawn, and the applicant must re-apply under section (2) or (3) of this rule.

(9) The division may extend the six-month period to complete a code certification training pursuant to (3)(b)(B) of this rule in the case of hardship or illness. The person must submit a request for extension to the division in writing.

(10) Persons with a valid Oregon Inspector Certification and a valid International Code Council certification or other nationally recognized certification identified in subsection (3)(d) of this rule, proof of passage of the International Code Council Building Official Legal/Management examination, or an International Code Council Certified Building Official certification may continue to perform work for which a certification is required until November 1, 2016. Persons who have not obtained the appropriate Oregon certification by November 1, 2016, may not perform duties as a building official or perform inspections or plan reviews for which an Oregon certification is required.

Stat. Auth.: ORS 455.720, 455.730 & 455.735

Stats. Implemented: ORS 455.720, 455.730 & 455.735

Hist.: BCD 16-2005(Temp), f. & cert. ef. 7-7-05 thru 12-31-05; BCD 24-2005, f. 9-30-05, cert. ef. 10-1-05; BCD 4-2006, f. 3-31-06, cert. ef. 4-1-06; BCD 19-2006, f. 12-29-06, cert. ef. 1-1-07; BCD 6-2010, f. 5-14-10, cert. ef. 7-1-10; BCD 7-2011, f. & cert. ef. 3-11-11; BCD 24-2011, f. 7-26-11, cert. ef. 10-1-11; BCD 1-2016(Temp), f. & cert. ef. 1-26-16 thru 7-23-16; BCD 6-2016, f. & cert. ef. 4-1-16; BCD 8-2016, f. 6-30-16, cert. ef. 7-1-16

918-098-1028

Oregon Inspector Certification Renewal Process

Effective July 1, 2016:

(1) All Oregon Inspector Certifications expire on November 1, 2016, and every three years thereafter.

(2) Oregon Inspector certification renewals must be completed on or prior to the certification expiration date.

(3) To renew an Oregon Inspector Certification a person must:

(a) Submit the renewal form;

(b) Demonstrate completion of all continuing education requirements; and

(c) Submit the certification renewal fee of $125 for a three year term.

(4) The division mails one renewal notification to the last known address of the certification holder at least 45 days prior to certification expiration. It is the responsibility of the certification holder to notify the division of a change of address.

Stat. Auth.: ORS 455.720, 455.730 & 455.735

Stats. Implemented: ORS 455.720, 455.730 & 455.735

Hist.: BCD 6-2010, f. 5-14-10, cert. ef. 7-1-10; BCD 7-2011, f. & cert. ef. 3-11-11; BCD 24-2011, f. 7-26-11, cert. ef. 10-1-11; BCD 8-2016, f. 6-30-16, cert. ef. 7-1-16

918-098-1100
2016 Certification Transition

(1) Notwithstanding OAR 918-098-1025, the division may issue an equivalent Oregon Code Certification to a person with a valid Oregon Inspector Certification, a valid appropriate International Code Council Certification, or an appropriate nationally recognized certification or license, issued prior to April 1, 2016, for:

(a) Commercial Building Inspector;

(b) Commercial Building Plans Examiner;

(c) Commercial Fire Plans Examiner;

(d) Commercial Mechanical Inspector;

(e) Residential Building Inspector;

(f) Residential Mechanical Inspector;

(g) Residential Plans Examiner; and

(h) Any other International Code Council or other nationally recognized certification the division determines is equivalent to an Oregon Code Certification.

(2) Notwithstanding OAR 918-098-1025, the division may issue an Oregon Building Official certification to a person with a valid Oregon Inspector Certification issued prior to April 1, 2016; and

(a) Successfully passed an International Code Council Building Official Legal/Management examination prior to April 1, 2016; or

(b) Obtained a valid International Code Council Certified Building Official certification prior to April 1, 2016.

(3) The division may deny the issuance of an equivalent Oregon certification under (1) and (2) of this rule if:

(a) A final order, including a consent order or default order, has been issued against the person pursuant to ORS chapter 455;

(b) The person is unable to produce evidence of a valid nationally recognized certification or successful passage of an International Code Council Building Official Legal/Management examination;

(c) The person has not completed all required continuing education for the certification pursuant to section (4) of this rule; or

(d) In addition to any other authority, the division finds the person is not entitled to possess the equivalent Oregon certification because of any prejudicial or unlawful action, including but not limited to, demonstrated lack of code knowledge, failing to properly administer the code, and not acting in the public interest.

(4) For the period between November 1, 2013 and November 1, 2016, code change continuing education is required for a person who received a certification before the effective date of a new applicable Oregon code for the certification. If the applicable Oregon code for the certification has not changed since the person received the certification, or if the division determined code change continuing education was not necessary for the applicable code, no code change continuing education is required.

(5) If a certification holder fails to complete required continuing education for a given certification by the deadline for renewal of their Oregon Inspector Certification, the certification for which they did not complete continuing education will be denied and the person may not re-apply for the certification pursuant to OAR 918-098-1025 for the three-year period covered by the Oregon Inspector Certification. Instead, to obtain the certification, the person must reapply and successfully pass an examination administered by the division.

(6) Applicants who fail the examination under section (5) of this rule may reapply and retest for a fee of $80.

(7) Persons who have not obtained the appropriate Oregon certification by November 1, 2016 may not perform duties as a building official or perform inspections or plan reviews for which an Oregon Code Certification is required.

Stat. Auth.: ORS 455.622, 455.720 & 455.730
Stat. Implemented: ORS 455.622, 455.720 & 455.730
Hist.: BCD 8-2016, f. 6-30-16, cert. ef. 7-1-16

918-098-1475
Conflict of Interest for Building Officials, Inspectors, and Plans Examiners

(1) A person with an Oregon Inspector Certification and an Oregon Code Certification may not get paid to perform or manage work regulated by the state building code for a company engaged in construction or property development in Oregon when employed as an inspector, plans examiner, or building official by the division, a municipality, or a registered business under ORS 455.457.

(2) Notwithstanding (1), a person hired by the division, a municipality, or a registered business under ORS 455.457 may continue to perform or manage work for a company engaged in construction or property development in Oregon for 6 months after hire only as necessary to complete or transition previously accepted work, if:

(a) The person does not engage in any conflicts of interest;

(b) The person submits written notice to the jurisdiction that hired them of their intent to continue outside work; and

(c) The jurisdiction that hired the person consents in writing to the continued outside work.

(3) For the purposes of this section "engaged in construction or property development" includes, but is not limited to:

(a) Designing, testing, or auditing of buildings or other structures, devices, and equipment regulated by the state building code; and

(b) Selling products or services that design, test, or audit buildings or other structures, devices, and equipment that are regulated by the state building code or that provide information related to the requirements of the state building code.

(4) For the purposes of this section, "employed" means working directly for an employer as an employee and completing a withholding exemptions certificate required by ORS 316.162 to 316.212.

(5) For the purposes of this section, "paid" means receiving any compensation from any source.

Stat. Auth.: ORS 455.720
Stat. Implemented: 455.720
Hist.: BCD 8-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Amendments to Oregon Mechanical Specialty Code.
Adm. Order No.: BCD 9-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 4-1-2016
Rules Amended: 918-440-0012
Subject: This rule amends the Oregon Mechanical Specialty Code to define deck or conveyor pizza ovens as light-duty cooking appliances.
Rules Coordinator: Holly A. Tucker—(503) 378-5331

918-440-0012
Amendments to the Oregon Mechanical Code

(1) The Oregon Mechanical Specialty Code is amended pursuant to OAR chapter 918, division 8. Amendments adopted for inclusion into the Oregon Mechanical Specialty Code are placed in this rule, showing the section reference, a descriptive caption, and a short description of the amendment.

(2) Effective July 1, 2016, the Oregon Mechanical Specialty Code, Section 202, is amended to define deck or conveyor pizza ovens as light-duty cooking appliances.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 455.030
Stats. Implemented: ORS 455.110
Hist.: BCD 32-1994, f. & cert. ef. 12-30-94; BCD 2-1996, f. 2-2-96, cert. ef. 4-1-96; BCD 5-1997, f. 3-21-97, cert. ef. 4-1-97; BCD 19-1998, f. 9-30-98, cert. ef. 10-1-98; BCD 15-1999, f. & cert. ef 10-6-99 thru 4-2-00; BCD 5-2000, f. 3-9-00, cert. ef. 4-1-00; BCD 8-2001, f. 7-17-01, cert. ef. 10-1-01; BCD 19-2003, f. 12-15-03, cert. ef. 1-1-04; BCD 10-2004, f. 8-6-04 cert. ef. 10-1-04; BCD 9-2006, f. 6-30-06, cert. ef. 7-1-06; Renumbered from 918-440-0040 by BCD 3-2010, f. 5-14-10, cert. ef. 7-1-10; Renumbered from 918-440-0040 by BCD 5-2011, f. & cert. ef. 3-11-11; Renumbered from 918-440-0040 by BCD 22-2011, f. 7-26-11, cert. ef. 10-1-11; BCD 37-2011, f. 12-30-11, cert. ef. 1-1-12; BCD 6-2014, f. 6-20-14, cert. ef. 7-1-14; BCD 9-2016, f. 6-30-16, cert. ef. 7-1-16

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Department of Consumer and Business Services, Director's Office
Chapter 440

Rule Caption: Outlines the Division of Financial Regulation's authority for administering existing rules and orders.
Adm. Order No.: DO 1-2016(Temp)
Filed with Sec. of State: 6-23-2016
Certified to be Effective: 6-29-16 thru 12-23-16
Notice Publication Date:
Rules Adopted: 440-001-9001
Subject: Whenever any rule, order, document, record or proceeding refers to the Oregon Insurance Division or the Division of Finance and Corporate Securities, the reference is considered to be a reference to the Division of Financial Regulation. The substitution of the Division of Financial Regulation for the Oregon Insurance Division

and the Division of Finance and Corporate Securities does not affect any legal rights, responsibilities, or obligations of the Director, Divisions or any licensee or registrant. The substitution of the Division of Financial Regulation for the Oregon Insurance Division and the Division of Finance and Corporate Securities does not affect the rules currently or previously adopted by the Oregon Insurance Division contained in Oregon Administrative Rule chapter 836 or the rules currently or previously adopted by the Division of Finance and Corporate Securities contained in Oregon Administrative Rule chapter 441.

Rules Coordinator: Jenny Craig—(503) 947-7866

440-001-9001

Division of Financial Regulation Scope of Authority

Whenever any rule, order, document, record or proceeding refers to the Oregon Insurance Division or the Division of Finance and Corporate Securities, the reference is considered to be a reference to the Division of Financial Regulation. The substitution of the Division of Financial Regulation for the Oregon Insurance Division and the Division of Finance and Corporate Securities does not affect any legal rights, responsibilities, or obligations of the Director, Divisions or any licensee or registrant. The substitution of the Division of Financial Regulation for the Oregon Insurance Division and the Division of Finance and Corporate Securities does not affect the rules currently or previously adopted by the Oregon Insurance Division contained in Oregon Administrative Rule chapter 836 or the rules currently or previously adopted by the Division of Finance and Corporate Securities contained in Oregon Administrative Rule chapter 441.

Stat. Auth.: 705.135
Stat. Implemented: 705.115
Hist.: DO 1-2016(Temp), f. 6-23-16, cert. ef. 6-29-16 thru 12-23-16

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Department of Consumer and Business Services, Insurance Regulation
Chapter 836

Rule Caption: Requirements for limited lines travel producers directing travel retailers to offer and disseminate travel insurance.
Adm. Order No.: ID 7-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Adopted: 836-071-0450
Rules Amended: 836-071-0108
Subject: Senate Bill 715 updated Oregon's producer licensing requirements for travel insurance based on a model act adopted by the National Conference of Insurance Legislators in November 2012, as well as uniform licensing standards adopted by the National Association of Insurance Commissioners in late 2010. The bill permits licensed insurance providers to be the licensees for products distributed through non-insurance travel retailers if specific conditions protecting consumers are met, including registration of the agents, training, and consumer disclosures. The proposed rules establish direction, for limited travel insurance producers to arrange travel insurance through travel retailers. The rules set out the conditions that must be met for the limited travel insurance producer to establish and maintain a register of required information for travel insurance retailers that arrange travel insurance through the limited travel insurance producer. The rules also address requirements for training travel retailers.
Rules Coordinator: Karen Winkel—(503) 947-7694

836-071-0108

Limited Class Insurance Licenses

For the purpose of ORS 744.062, the Director establishes the following classifications for limited class insurance licenses, for use on and after July 1, 2005:

(1) Under a "limited class credit insurance" license, the licensee may transact the following classes of insurance when the insurance is offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation:

(a) Credit life insurance. Under this class, an insurance producer may transact credit life insurance as approved under ORS 743.371(1).

(b) Credit health insurance. Under this class an insurance producer may transact credit health insurance as approved under ORS 743.371(2).

(c) Credit unemployment and involuntary unemployment insurance. Under this class an insurance producer may transact approved liability coverage for unemployment.

(d) Credit property insurance. Under this class, an insurance producer may transact insurance against property loss or damage that may result in failure of debtors to pay their obligations to the insured, including but not limited to motor vehicle physical damage insurance. This class does not include mortgage insurance.

(e) Mortgage guarantee insurance. Under this class, an insurance producer may transact only the insurance that is issued by an authorized mortgage insurer under ORS 742.282 to 742.286.

(f) Mortgage life or disability insurance, or mortgage life and disability insurance. Under this class, a lending institution may transact mortgage cancellation insurance as approved under ORS 743.303(1)(b) and (5).

(g) Gap insurance. This class applies to a person described in ORS 731.036(9) who does not qualify for the exemption in 731.036(9) because the person imposes an additional charge to waive the amount described in 731.036(9)(b) pursuant to an agreement to lease or to finance the purchase of a motor vehicle.

(2) Under a "limited class insurance" license, the licensee may transact the following classes of insurance:

(a) Crop insurance. Under this class, an insurance producer may place insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease or other yield-reducing conditions or perils provided by the private insurance market, or that is subsidized by the Federal Crop Insurance Corporation, including multi-peril crop insurance.

(b) Surety insurance. Under this class an insurance producer may place insurance or a bond that covers obligations to pay the debts of, or answer for the default of another, including faithlessness in a position of public or private trust as approved under ORS 742.350 to 742.376. For the purpose of this limited line license, surety does not include surety bail bonds.

(c) Mechanical breakdown insurance. Under this class an insurance producer may place insurance that provides repair or replacement service, or indemnification for repair or replacement service, for operational or structural failure of property due to defects in materials or workmanship or normal wear and tear, including but not limited to motor vehicles, mobile equipment, boats, appliances and electronics.

(3) Travel insurance. Under this class as defined in ORS 744.101, a limited travel insurance producer and any travel retailer offering travel insurance on behalf of and at the direction of a limited travel insurance producer shall comply with the requirements set forth in OAR 836-071-0450.

(4) For the purpose of making the transition to a mechanical breakdown insurance limited class insurance license under section (2) of this rule rather than as a limited class credit insurance license under section (1) of this rule, the change shall apply to renewals of limited class credit insurance licenses applied for on or after January 1, 2013. A licensee transacting mechanical breakdown insurance under a limited class credit insurance license may continue to do so until the first renewal of the limited class credit license after January 1, 2013.

Stat. Auth.: ORS 731.244, 744.062, 744.104, 744.111
Stats. Implemented: ORS 744.062, 744.101, 744.104, 744.111
Hist.: ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 18-2012, f. & cert. ef. 11-7-12; ID 7-2016, f. 6-30-16, cert. ef. 7-1-16

836-071-0450

Requirements for Limited Travel Insurance Producer and Travel Retailer

(1) In order to comply with ORS 744.104(2)(b), a limited travel insurance producer shall:

(a) Establish and maintain a register containing all of the information required under ORS 744.104(2)(a);

(b) Include on the register:

(A) The license number of any person described in ORS 744.104(d) and 744.104(e) who is a licensed insurance producer; or

(B) The fingerprints and background check results of any person described in ORS 744.104(d) and 744.104(e) who is not a licensed insurance producer; and

(c) Use the model form provided by the Director of the Department of Consumer and Business Services at www.insurance.oregon.gov or a substantially similar form filed with and approved by the director;

(d) Update retained information recorded on the register at least annually

(e) Maintain the register in such a manner that the document and all necessary required attachments are available to be submitted in electronic form to the director within 30 days of a request as under ORS 744.104(2)(c);

(f) Maintain records of the register after the expiration of a policy as required under ORS 744.068; and

(g) Notify the director in writing of any material changes in the affidavit described in ORS

(2) All persons specified in ORS 744.104(2)(d) must:

(a) Hold a license as an insurance producer under ORS 744.052 to 744.089;

(3) All persons specified in ORS 744.104(2)(e) must:

(a) Furnish fingerprints and results from criminal history check as defined under OAR 836-072-0010 to the limited travel insurance producer keeping the register required under ORS 744.104(2)

(4) A program of instruction or training described under ORS 744.104(2)(g) shall:

(a) Include compliance with requirements under ORS 744.104(3) and (4);

(b) Address the types of insurance offered by the limited travel insurance producer and ethical sales practices; and

(c) Be provided at least annually for all active travel retail employees.

Stat. Auth.: ORS 731.244, 744.062 , 744.104, 744.111
Stats. Implemented: ORS 744.062, 744.101, 744.104, 744.107
Hist.: ID 7-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Eliminating duplicate notice requirements for long term care insurance.
Adm. Order No.: ID 8-2016
Filed with Sec. of State: 7-6-2016
Certified to be Effective: 7-6-16
Notice Publication Date: 5-1-2016
Rules Amended: 836-052-0740
Rules Repealed: 836-052-0536
Subject: This rulemaking repeals an existing Financial Regulation Division rule. OAR 836-052-0536 whose requirements are now established in ORS 743.658 and changes an internal reference to OAR 836-052-0536 in 836-052-0740(7) to reflect this change.
Rules Coordinator: Karen Winkel—(503) 947-7694

836-052-0740
Right to Reduce Coverage and Lower Premiums

(1) Every long term care insurance policy and certificate must include a provision that allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(a) Reducing the maximum benefit; or

(b) Reducing the daily, weekly, or monthly benefit amount.

(2) An insurer may offer other reduction options that are consistent with the policy or certificate design or the insurer's administrative processes, in addition to the provision required in section (1) of this rule.

(3) If a reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer must allow the policyholder to continue the benefit amount in effect at the time of the reduction.

(4) The provision required in section (1) of this rule must include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(5) The premium for the reduced coverage shall:

(a) Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and

(b) Be consistent with the approved rate table.

(6) The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(7) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificate holder of the right of the policyholder or certificate holder to reduce coverage and premiums in the notice required by ORS 743.658.

(8) This rule does not apply to life insurance policies or riders containing accelerated long term care benefits.

(9) This rule applies to any long term care policy issued in this state on or after December 1, 2008.

(10) A premium increase notice required by OAR 836-052-0556(5) shall include:

(a) Information about the amount requested and the implementation schedule;

(b) Available benefit reduction or rate increase mitigation actions and the impact such action will have on the policy, such as the loss of asset protection in a partnership plan;

(c) A disclosure stating that all options available to the policyholder may not be of equal value;

(d) Clear disclosure addressing guaranteed renewable nature of policy and possibility of future rate increases;

(e) Offer of contingent benefit upon lapse or other nonforfeiture benefits, if applicable;

(f) Information about how to contact the insurer;

(g) A statement that the increase is on a class basis rather than for a particular individual and is related to expected future claims rather than economic conditions; and

(h) In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

(11) The requirements of section (10) of this rule apply to any rate increase implemented in this state on or after January 1, 2016.

Stat. Auth.: ORS 731.244
Stats. Implemented: Sec. 9, Ch. 486, OL 2007 (Enrolled SB 191)
Hist.: ID 10-2007, f. 12-3-07, cert. ef. 1-1-08; ID 5-2015, f. 6-10-15, cert. ef. 1-1-16; ID 8-2016, f. & cert. ef. 7-6-16

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Department of Fish and Wildlife
Chapter 635

Rule Caption: Additional Commercial Spring Salmon and Shad Fishing Periods Authorized for Columbia River Select Areas
Adm. Order No.: DFW 78-2016(Temp)
Filed with Sec. of State: 6-23-2016
Certified to be Effective: 6-23-16 thru 7-31-16
Notice Publication Date:
Rules Amended: 635-042-0160, 635-042-0170
Rules Suspended: 635-042-0160(T), 635-042-0170(T)
Subject: This amended rule adds one new 12-hour fishing period in Blind and Knappa sloughs, and two new 12-hour periods in the Tongue Pont/South Channel commercial spring Chinook fisheries of the Columbia River of the Select Areas. Modifications are consistent with action taken June 22, 2016 by the Oregon and Washington Departments of Fish and Wildlife at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-042-0160
Blind Slough and Knappa Slough Select Area Salmon Season

(1) Salmon and shad may be taken for commercial purposes during open 2016 fishing periods described as the winter fishery and the spring fishery in subsections (1)(a)(A) and (1)(a)(B) respectively, of this rule in those waters of Blind Slough and Knappa Slough. Retention and sale of white sturgeon is prohibited. Retention and sales of non-adipose finclipped Chinook salmon from the Blind Slough Select area is prohibited from 12:00 noon through midnite on March 29, 2016. The following restrictions apply:

(a) The open fishing periods are established in segments categorized as the winter fishery in Blind Slough and Knappa Slough in subsection (1)(a)(A), the winter fishery in Blind Slough only in subsection (1)(a)(B), and the spring fishery in Blind Slough and Knappa Slough in subsection (1)(a)(C). The seasons are open nightly from 7:00 p.m. to 7:00 a.m. the following morning (12 hours), as follows:

(A) Blind Slough and Knappa Slough:
Monday, Wednesday and Thursday nights beginning Monday, February 8 through Friday, March 11 (15 nights);
Monday, March 14 (1 night); and
Thursday, March 17 (1 night).

(B) Blind Slough Only: Monday and Thursday nights beginning Monday, March 21 through Tuesday, March 29 (3 nights).

(C) Blind Slough and Knappa Slough Thursday and Monday nights from 7:00 p.m. to 7:00 a.m. the following morning (12 hours) beginning Thursday, April 28 through Tuesday, June 28, 2016 (18 nights).

(b) The fishing areas for the winter and spring seasons are:

(A) Blind Slough are those waters from markers at the mouth of Blind Slough upstream to markers at the mouth of Gnat Creek which is located approximately 1/2 mile upstream of the county road bridge.

(B) Knappa Slough are all waters bounded by a line from the northerly most marker at the mouth of Blind Slough westerly to a marker on

Karlson Island downstream to a north-south line defined by a marker on the eastern end of Minaker Island to markers on Karlson Island and the Oregon shore.

(C) During the period from May 2 through June 14, the Knappa Slough fishing area extends downstream to the boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon shore.

(c) Gear restrictions are as follows:

(A) During the winter and spring fisheries, outlined above in subsections (1)(a)(A), (1)(a)(B), (1)(a)(C) and (1)(a)(D), gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. The attachment of additional weight and/or anchors directly to the lead line is permitted.

(B) It is unlawful to use a gill net having a mesh size that is less than 7-inches during the winter fishery or greater than 9.75-inches during the spring fishery.

(C) Nets not specifically authorized for use in these areas may be onboard a 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.

(2) Oregon licenses are required in the open waters upstream from the railroad bridge.

Stat. Auth.: ORS 183.325, 506.109 & 506.119

Stats. Implemented: ORS 506.129 & 507.030

Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998(Temp), f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 65-2000(Temp) f. 9-22-00, cert. ef. 9-25-00 thru 12-31-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 86-2001, f. & cert. ef. 9-4-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 14-2002(Temp), f. 2-13-02, cert. ef. 2-18-02 thru 8-17-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 16-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 16-2006(Temp), f. 3-23-06 & cert. ef. 3-26-06 thru 7-27-06; DFW 18-2006(Temp), f. 3-29-06, cert. ef. 4-2-06 thru 7-27-06; DFW 20-2006(Temp), f. 4-7-06, cert. ef. 4-9-06 thru 7-27-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06; DFW 75-2006(Temp), f. 8-8-06, cert. ef. 9-5-06 thru 12-31-06; DFW 92-2006(Temp), f. 9-1-06, cert. ef. 9-5-06 thru 12-31-06; DFW 98-2006(Temp), f. & cert. ef. 9-12-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; 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 13-2007(Temp), f. & cert. ef. 3-6-07 thru 9-1-07; DFW 25-2007(Temp), f. 4-17-07, cert. ef. 4-18-07 thru 7-26-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative correction 1-24-08; DFW 6-2008(Temp), f. 1-29-08, cert. ef. 1-31-08 thru 7-28-08; DFW 16-2008(Temp), f. 2-26-08, cert. ef. 3-2-08 thru 8-28-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert . ef. 8-1-08 thru 12-31-08; DFW 103(Temp), f. 8-26-08, cert. ef. 9-2-08 thru 10-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 49-2009(Temp), f. 5-14-09, cert. ef 5-17-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 15-2010(Temp), f. 2-19-10, cert. ef. 2-21-10 thru 6-11-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. & cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 44-2011(Temp), f. & cert. ef. 5-11-11 thru 6-10-11; Administrative correction 6-28-11; DFW 113-2011(Temp), f. 8-10-11, cert. ef. 8-15-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 12-2012(Temp), f. 2-8-12, cert. ef. 2-12-12 thru 7-31-12; DFW 104-2012(Temp), f. 8-6-12, cert. ef. 8-13-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef. 2-11-13 thru 7-31-13; DFW 24-2013(Temp), f. & cert. ef. 3-21-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 91-2013(Temp), f. 8-22-13, cert. ef. 8-26-13 thru 10-31-13; DFW 110-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 115-2014(Temp), f. 8-5-14, cert. ef. 8-18-14 thru 10-31-14; DFW 135-2014(Temp), f & cert. ef. 9-19-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 29-2015(Temp), f. & cert. ef. 4-21-15 thru 7-30-15; DFW 37-2015(Temp), f. 5-1-15, cert. ef. 5-4-15 thru 7-30-15; DFW 70-2015(Temp), f. 6-15-15, cert. ef. 6-16-15 thru 7-31-15; DFW 76-2015(Temp), f. 6-23-15, cert. ef. 6-25-15 thru 7-31-15; DFW 102-2015(Temp), f. 8-10-15, cert. ef. 8-17-15 thru 10-31-15; Administrative correction, 11-20-15; DFW 8-2016(Temp), f. 2-1-16, cert. ef. 2-8-16 thru 7-31-16; DFW 23-2016(Temp), f. & cert. ef. 3-28-16 thru 7-31-16; DFW 32-2016(Temp), f. 4-20-16, cert. ef. 4-21-16 thru 7-31-16; DFW 71-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 78-2016(Temp), f. 6-23-16 thru 7-31-16

635-042-0170

Tongue Point Basin and South Channel

(1) Tongue Point includes all waters bounded by a line extended from the upstream (southern most) pier (#1) at the Tongue Point Job Corps facility through navigation marker #6 to Mott Island, a line from a marker at the southeast end of Mott Island northeasterly to a marker on the northwest tip of Lois Island, and a line from a marker on the southwest end of Lois Island westerly to a marker on the Oregon shore.

(2) South Channel area includes all waters bounded by a line from a marker on John Day Point to a marker on the southwest end of Lois Island upstream to an upper boundary line from a marker on Settler Point northwesterly to the flashing red USCG marker #10, northwesterly to a marker on the eastern tip of Burnside Island defining the upstream terminus of South Channel.

(3) Salmon and shad may be taken for commercial purposes in those waters of Tongue Point and South Channel as described in section (1) and section (2) of this rule. Retention and sale of white sturgeon is prohibited. The 2016 open fishing periods are:

(a) Winter Season:

Monday and Thursday nights from 7:00 p.m. to 7:00 a.m. the following morning (12 hours) beginning Monday, February 8 through Friday, March 11 (10 nights).

(b) Spring Season:

Thursday and Monday nights from 7:00 p.m. to 7:00 a.m. the following morning (12 hours) beginning Thursday, May 5 through Tuesday, June 28 (16 nights).

(4) Gear restrictions are as follows:

(a) In waters described in section (1) as Tongue Point basin, gill nets may not exceed 250 fathoms in length and weight limit on the lead line is not to exceed two pounds on any one fathom. It is unlawful to use a gill net having a mesh size that is less than 7 inches during the winter season or more than 9.75-inches during the spring season.

(b) In waters described in section (2) as South Channel, nets are restricted to 250 fathoms in length with no weight restrictions on the lead line. The attachment of additional weight and/or anchors directly to the lead line is permitted. It is unlawful to use a gill net having a mesh size that is less than 7 inches during the winter season or more than 9.75 inches during the spring season.

(c) Nets not specifically authorized for use in these areas may be onboard a 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.

Stat. Auth.: ORS 183.325, 506.109 & 506.119

Stats. Implemented: ORS 506.129 & 507.030

Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; FWC 61-1997(Temp), f. 9-23-97, cert. ef. 9-24-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 41-1998(Temp), f. 5-28-98, cert. ef. 5-29-98; DFW 42-1998(Temp), f. 5-29-98, cert. ef. 5-31-98 thru 6-6-98; DFW 45-1998(Temp), f. 6-5-98, cert. ef. 6-6-98 thru 6-10-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998, f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; Administrative correction 7-30-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 76-2006(Temp), f. 8-8-06, cert. ef. 9-5-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative Correction 1-24-08; DFW 44-2008(Temp), f. 4-25-08, cert. ef. 4-28-08 thru 10-24-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert. ef. 8-1-08 thru 12-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 29-2010(Temp), f. 3-9-10, cert. ef. 4-19-10 thru 6-12-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. &

cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 44-2011(Temp), f. & cert. ef. 5-11-11 thru 6-10-11; Administrative correction 6-28-11; DFW 113-2011(Temp), f. 8-10-11, cert. ef. 8-15-11 thru 10-31-11; DFW 122-2011(Temp), f. 8-29-11, cert. ef. 9-19-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 41-2012(Temp), f. 4-24-12, cert. ef. 4-26-12 thru 6-30-12; Administrative correction, 8-1-12; DFW 104-2012(Temp), f. 8-6-12, cert. ef. 8-13-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef. 2-11-13 thru 7-31-13; DFW 34-2013(Temp), f. 5-14-13, cert. ef. 5-15-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 91-2013(Temp), f. 8-22-13, cert. ef. 8-26-13 thru 10-31-13; DFW 110-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 115-2014(Temp), f. 8-5-14, cert. ef. 8-18-14 thru 10-31-14; DFW 135-2014(Temp), f & cert. ef. 9-19-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 29-2015(Temp), f. & cert. ef. 4-21-15 thru 7-30-15; DFW 37-2015(Temp), f. 5-1-15, cert. ef. 5-4-15 thru 7-30-15; DFW 102-2015(Temp), f. 8-10-15, cert. ef. 8-17-15 thru 10-31-15; Administrative correction, 11-20-15; DFW 8-2016(Temp), f. 2-1-16, cert. ef. 2-8-16 thru 7-31-16; DFW 32-2016(Temp), f. 4-20-16, cert. ef. 4-21-16 thru 7-31-16; DFW 71-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 78-2016(Temp), f. 6-23-16 thru 7-31-16

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Rule Caption: July 1 White Sturgeon Recreational Fishery in Bonneville Pool Rescinded
Adm. Order No.: DFW 79-2016(Temp)
Filed with Sec. of State: 6-23-2016
Certified to be Effective: 6-30-16 thru 12-26-16
Notice Publication Date:
Rules Amended: 635-023-0095
Rules Suspended: 635-023-0095(T)
Subject: This amended rule rescinds the recreational white sturgeon fishery in the Bonneville Pool that was previously scheduled to begin July 1, 2016 for one day only. The annual white sturgeon retention guideline for the Bonneville Pool has been attained. Revisions are consistent with action taken June 22, 2016 by the Departments of Fish and Wildlife, for the States of Oregon and Washington, at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-023-0095
Sturgeon Season

(1) The **2016 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 **2016 Oregon Sport Fishing Regulations**.

(2)(a) Retention of white sturgeon in the Columbia River from Bonneville Dam upstream to The Dalles Dam (Bonneville Pool), including adjacent tributaries, is prohibited from 12:01 a.m Sunday, June 19 until further notice.

(b) Catch-and-release angling is allowed during periods closed to sturgeon retention.

(c) All other limits, restrictions and regulations for the Bonneville Pool as described in the **2016 Fishing Regulations** remain in effect.

(3)(a) Retention of white sturgeon in the Columbia River from The Dalles Dam upstream to the John Day Dam (The Dalles Pool), including adjacent tributaries, is prohibited from 12:01 a.m. Saturday, April 30, 2016 until further notice.

(b) Catch-and-release angling is allowed during periods closed to sturgeon retention.

(c) All other limits, restrictions and regulations for The Dalles Pool as described in the **2016 Oregon Sport Fishing Regulations** remain in effect.

(4)(a) Retention of white sturgeon in the Columbia River from The John Day Dam upstream to McNary Dam (John Day Pool), including adjacent tributaries, is prohibited from 12:01 a.m. Sunday, May 29, 2016 until further notice.

(b) Catch-and-release angling is allowed during periods closed to sturgeon retention.

(c) All other limits, restrictions and regulations for the John Day Pool as described in the **2016 Oregon Sport Fishing Regulations** remain in effect.

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; DFW 104-2013(Temp), f. 9-13-13, cert. ef. 10-19-13 thru 12-31-13; DFW 126-2013(Temp), f. 10-31-13, cert. ef. 11-12-13 thru 12-31-13; DFW 135-2013(Temp), f. 12-12-13, cert. ef. 1-1-14 thru 1-31-14; DFW 137-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 5-2014(Temp), f. 1-30-14, cert. ef. 2-1-14 thru 7-30-14; DFW 14-2014(Temp), f. 2-20-14, cert. ef. 2-24-14 thru 7-31-14; DFW 27-2014(Temp), f. 3-28-14, cert. ef. 5-1-14 thru 7-31-14; DFW 56-2014(Temp), f. 6-9-14, cert. ef. 6-13-14 thru 7-31-14; DFW 87-2014(Temp), f. 7-2-14, cert. ef. 7-11-14 thru 12-31-14; DFW 94-2014(Temp), f. & cert. ef. 7-14-14 thru 12-31-14; DFW 165-2014, f. 12-18-14, cert. ef. 1-1-15; DFW 166-2014(Temp), f. 12-18-14, cert. ef. 1-1-15 thru 3-1-15; Administrative correction, 3-23-15; DFW 41-2015(Temp), f. & cert. ef. 5-12-15 thru 7-31-15; DFW 54-2015(Temp), f. 5-28-15, cert. ef. 6-3-15 thru 7-31-15; DFW 89-2015(Temp), f. 7-16-15, cert. ef. 7-18-15 thru 9-30-15; Temporary suspended by DFW 122-2015(Temp), f. 8-31-15, cert. ef. 9-1-15 thru 9-30-15; Administrative correction, 10-22-15; DFW 167-2015, f. 12-29-15, cert. ef. 1-1-16; DFW 7-2016(Temp), f. 1-28-16, cert. ef. 2-8-16 thru 8-05-16; DFW 36-2016(Temp), f. 4-26-16, cert. ef. 5-1-16 thru 7-31-16; DFW 42-2016(Temp), f. 4-27-16, cert. ef. 4-30-16 thru 7-31-16; DFW 56-2016(Temp), f. 5-25-16, cert. ef. 5-29-16 thru 11-24-16; DFW 56-2016(Temp), f. 5-26-16, cert. ef. 5-29-16 thru 11-24-16; DFW 79-2016(Temp), f. 6-23-16, cert. ef. 6-30-16 thru 12-26-16

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Rule Caption: Spring Chinook Fisheries Open July 2 on the Wallowa River.
Adm. Order No.: DFW 80-2016(Temp)
Filed with Sec. of State: 6-24-2016
Certified to be Effective: 7-2-16 thru 8-31-16
Notice Publication Date:
Rules Amended: 635-019-0090
Rules Suspended: 635-019-0090(T)
Subject: This amended rule allows recreational anglers opportunities to harvest adipose fin-clipped adult Chinook salmon and adipose fin-clipped jack Chinook salmon, which are in excess of the Department's hatchery production needs, in the Wallowa River beginning Saturday, July 2, 2016 and until harvest guidelines are met.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-019-0090
Inclusions and Modifications

(1) The **2016 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 **2016 Oregon Sport Fishing Regulations**.

(2) 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 June 15, 2016 until further notice.

(a) 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 is met.

(b) Statewide hook regulations apply: Single point hooks larger than 1 inch gap and multiple point hooks larger than 9/16 inch gap are prohibited.

(c) All other General, Statewide and Northeast Zone Regulations, as provided in the **2016 Oregon Sport Fishing Regulations**, remain in effect.

(3) The Wallowa River from a deadline at the lower end of Minam State Park upstream to the confluence with the Lostine River is open to angling for adipose fin-clipped adult Chinook salmon from July 2, 2016 until further notice.

(a) 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 is met.

(b) Statewide hook regulations apply: Single point hooks larger than 1 inch gap and multiple point hooks larger than 9/16 inch gap are prohibited.

(c) All other General, Statewide and Northeast Zone Regulations, as provided in the **2016 Oregon Sport Fishing Regulations**, remain in effect.

Stat. Auth.: ORS 496.138, 496.146, 506.119
Stats. Implemented: ORS 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; Administrative correction 11-1-13; DFW 121-2013(Temp), f. 10-24-13, cert. ef. 11-1-13 thru 12-31-13; DFW 137-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 42-2014(Temp), f. 5-12-14, cert. ef. 5-17-14 thru 6-1-14; DFW 47-2014(Temp), f. 5-27-14, cert. ef. 5-31-14 thru 7-31-14; DFW 53-2014(Temp), f. 5-28-14, cert. ef. 6-1-14 thru 7-31-14; DFW 58-2014(Temp), f. 6-9-14, cert. ef. 6-21-14 thru 8-31-14; DFW 71-2014(Temp), f. 6-16-14, cert. ef. 6-18-14 thru 9-1-14; DFW 72-2014(Temp), f. & cert. ef. 6-19-14 thru 9-1-14; DFW 75-2014(Temp), f. 6-23-14, cert. ef. 6-27-14 thru 9-1-14; DFW 82-2014(Temp), f. 7-1-14, cert. ef. 7-5-14 thru 9-1-14; DFW 86-2014(Temp), f. 7-2-14, cert. ef. 7-5-14 thru 9-1-14; DFW 97-2014(Temp), f. 7-18-14, cert. ef. 7-21-14 thru 9-30-14; Administrative correction, 10-24-14; DFW 165-2014, f. 12-18-14, cert. ef. 1-1-15; DFW 45-2015(Temp), f. 5-15-15, cert. ef. 5-20-15 thru 6-30-15; DFW 53-2015(Temp), f. 5-27-15, cert. ef. 6-6-15 thru 8-31-15; DFW 64-2015(Temp), f. & cert. ef. 6-9-15 thru 8-31-15; DFW 81-2015(Temp), f. 7-1-15, cert. ef. 7-5-15 thru 8-31-15; DFW 88-2015(Temp), f. 7-16-15, cert. ef. 7-18-15 thru 12-31-15; DFW 99-2015(Temp), f. & cert. ef. 8-3-15 thru 12-31-15; DFW 121-2015(Temp), f. 8-31-15, cert. ef. 9-1-15 thru 12-31-15; DFW 167-2015, f. 12-29-15, cert. ef. 1-1-16; DFW 45-2016(Temp), f. 5-5-16, cert. ef. 5-10-16 thru 6-5-16; DFW 54-2016(Temp), 5-23-16, cert. ef. 5-18-16 thru 6-5-16; DFW 62-2016(Temp), f. 6-1-16, cert. ef. 6-15-16 thru 8-31-16; DFW 80-2016(Temp), f. 6-24-16, cert. ef. 7-2-16 thru 8-31-16

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Rule Caption: 2016-2017 Big Game Tag Numbers, Dates, and Regulations and Tag Numbers for 2017 Big Game
Adm. Order No.: DFW 81-2016
Filed with Sec. of State: 6-27-2016
Certified to be Effective: 6-27-16
Notice Publication Date: 5-1-2016
Rules Adopted: 635-008-0112
Rules Amended: 635-065-0001, 635-065-0760, 635-065-0765, 635-066-0010, 635-067-0000, 635-068-0000, 635-069-0000, 635-070-0000, 635-071-0000, 635-073-0000, 635-073-0100, 635-075-0022
Rules Repealed: 635-065-0001(T), 635-065-0765(T), 635-073-0000(T)
Subject: Set hunting season regulations and/or controlled hunt tag numbers for 2016 and 2017 for game mammals. Set tag numbers for the present year (2016) and tag numbers for next year (2017) in advance
Rules Coordinator: Michelle Tate—(503) 947-6044

635-008-0112
Junction City Pond (Lane County)

The Junction City Pond area is open for public use unless otherwise excluded or restricted by the following rules:

(1) Hunting is prohibited.

(2) Discharging firearms, crossbows, air guns, BB guns or paint ball guns is prohibited.

(3) Discharge of archery (recurve, long, or compound bows) is allowed only within the designated archery park.

(4) The area is closed to the public 10 pm to 4 am.

(5) Motor vehicles are prohibited except on parking areas or open roads: no cross-country travel or off road motor vehicle use allowed.

(6) Operating motor propelled boats prohibited.

(7) Open fires are prohibited.

(8) Trapping is prohibited except by access permit issued by ODFW.

(9) Dog training is prohibited.

(10) All dogs must be on a leash.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: DFW 81-2016, f. & cert. ef. 6-27-16

635-065-0001
Purpose and General Information

(1) Notwithstanding the provisions of the 2016 Oregon Big Game Regulations:

(a) The cost of a Uniformed Service Buck Deer Tag is $26.50 (page 6 of 2016 Oregon Big Game Regulations);

(b) No person younger than 14 years of age shall hunt with a firearm or bow and arrow unless person is accompanied by an adult, or is hunting on land owned by the parent or legal guardian of the person (per ORS 497.350)

(2) The purpose of these rules is to establish license and tag requirements, limits, areas, methods and other restrictions for hunting game mammals pursuant to ORS Chapter 496.

(3) OAR chapter 635, division 065 incorporates, by reference, the requirements for hunting game mammals set out in the document entitled 2016 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the" 2016 Oregon Big Game Regulations" in addition to OAR chapter 635, to determine all applicable requirements for game mammals. The annual Oregon Big Game Regulations are available at hunting license agents and regional, district, and headquarters offices, and website of the Oregon Department of Fish and Wildlife.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 38-1988, f. & cert. ef. 6-13-88; FWC 63-1989, f. & cert. ef. 8-15-89; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 82-2000, f. 12-21-00, cert. ef.

1-1-01; DFW 3-2002(Temp), f. & cert. ef. 1-3-02 thru 1-23-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 9-2003(Temp), f. & cert. ef. 1-28-03 thru 6-16-03; DFW 85-2003(Temp), f. & cert. ef. 8-27-03 thru 2-23-04; DFW 88-2003(Temp), f. & cert. ef. 9-3-03 thru 12-31-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 122-2004, f. 12-21-04, cert. ef. 1-1-05; DFW 128-2005, f. 12-1-05, cert. ef. 1-1-06; DFW 127-2006, f. 12-7-06, cert. ef. 1-1-07; DFW 118-2007, f. 10-31-07, c ert. ef. 1-1-08; DFW 150-2008, f. 12-18-08, cert. ef. 1-1-09; DFW 140-2009, f. 11-3-09, cert. ef. 1-1-10; DFW 168-2010, f. 12-29-10, cert. ef. 1-1-11; DFW 159-2011, f. 12-14-11, cert. ef. 1-1-12; DFW 147-2012, f. 12-18-12, cert. ef. 1-1-13; DFW 138-2013, f. & cert. ef. 12-20-13; DFW 1-2015, f. & cert. ef. 1-6-15; DFW 18-2016, f. & cert. ef. 3-21-16; DFW 22-2016(Temp), f. & cert. ef. 3-25-16 thru 9-20-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-065-0760
Other Restrictions

It is *unlawful*:

(1) To take or hold in captivity the young of any game mammal.

(2) To hold in captivity any wildlife of this state for which a permit is required without first securing a permit.

(3) To release without a permit any wildlife brought from another state or country, or raised in captivity in this state.

(4) To resist game law enforcement officers.

(5) To refuse inspection of any license, tag or permit by an employee of the Department; any person authorized to enforce the wildlife laws; or a landowner or agent of the landowner on his or her land while on that property.

(6) To refuse inspection, by an employee of the Oregon Department of Fish and Wildlife, or any person authorized to enforce wildlife laws, of any gear used for the purpose of taking wildlife.

(7) To take or attempt to take any game mammals, game birds, migratory waterfowl or any protected wildlife species of any size or sex or amount, by any method or weapon, during any time or in any area not prescribed in these rules.

(8) To disturb, damage, remove, alter or possess any official Department signs.

(9) To sell, lend, or borrow any big game tag.

(10) It is unlawful to operate or to be transported in a motor-propelled vehicle in violation of Cooperative Travel Management Areas. "Motor-propelled vehicle" includes aircraft not landing on designated airstrips. Through cooperative agreement, motor vehicle use is limited to specific roads during the dates for the areas listed below. There are two methods of posting road access information; negative marking in which closed roads are marked by signs, gates, berms, or other similar indicators, or positive marking in which open roads are marked by round green reflectors, orange carsonite posts, or similar indicators. Unit descriptions may be found in OAR 635-080-0000 through 635-080-0077. The following closures shall be effective during the specified periods each year:

(c) Luckiamute: Permanent Closure — Those parts of the Stott Mt. /Alsea Units as follows: 9 square miles in Townships 8 and 9 South, Ranges 7 and 8 West.

(d) Mid-Coast: Permanent Closure — That part of the Alsea Unit as follows: Open roads in the Siuslaw NF lands south of US Hwy 20 and north of State Hwy 126 are designated on the Siuslaw NF Motor Vehicle Use Map. However; additional roads may be posted as closed as part of the Cooperative TMA or for administrative purposes.

(e) Smith Ridge: Permanent Closure — That part of the McKenzie Unit as follows: 8 square miles in Townships 13 and 14 South, Ranges 6 and 7 East;

(f) Chucksney Mountain: September 1 through November 30 annually — That part of the McKenzie Unit as follows: 6 square miles in Township 19 South, Range 5 1/2 East;

(g) Skookum Flat: Permanent Closure — That part of the McKenzie Unit as follows: 8 square miles in Townships 19 and 20 South, Range 6 East;

(h) Scott Creek: Permanent Closure — That part of the McKenzie Unit as follows: 51 square miles in Townships 14, 15, and 16 South, Ranges 6 and 7 East;

(i) Wendling: opening of general buck deer season through November 30. Approximately 185 sq. mi in Unit 19 northeast of Springfield; north of Hwy 126, east of Marcola and Brush Creek Rds., and south of the Calapooia River Mainline. Roads open to motor vehicle use will be marked with orange road markers. Access may be closed due to fire danger.

(j) Coos Bay BLM: Permanent Closure — That part of the Tioga Unit as follows: Individual posted roads on lands administered by BLM, Coos Bay District.

(k) Upper Rogue: Three days prior to the general Cascade elk season through the end of the general Cascade elk season — That part of the Rogue Unit as follows: High Cascades Ranger District, Rogue River National Forest;

(l) Jackson: Three days prior to the general Cascade elk season through April 30 annually — That part of the Rogue, Dixon, and Evans Creek units as follows: 116 square miles in Townships

32, 33, 34, and 35 South, Ranges 1 and 2 West and 1 and 2 East; off-road motor vehicle travel is prohibited at all times;

(m) Pokegama: November 20 through March 31 annually — That part of the Keno Unit as follows: 97 square miles in Townships 40 and 41 South, Ranges 4, 5, and 6 East;

(n) Lower Klamath Hills: Permanent Closure — That part of the Klamath Unit as follows: 3 square miles in Township 40 South, Range 9 East;

(o) Goodlow Mountain Area Closure: December 1 through March 31 annually — That part of the Klamath Unit as follows: 17 square miles in Townships 38 and 39 South, Ranges 12 and 13 East;

(p) Sun Creek: November 1 through June 30 annually — That part of the Sprague Unit as follows: 14 square miles in Township 32 South, Ranges 6 and 7 1/2 East;

(q) Fox Butte: Three days prior to the opening of controlled buck deer season through the close of the controlled buck deer season — That part of the Paulina Unit as follows: 230 square miles in Townships 20, 21, 22, 23, and 24 South, Ranges 14, 15, and 16 East;

(r) Timbers: Permanent Closure — That part of the Paulina Unit as follows: 25 square miles in Townships 23 and 24 South, Ranges 9 and 10 East;

(s) Rager: Three days prior to the opening of controlled buck deer rifle season through the close of antlerless elk rifle season — That part of the Ochoco Unit as follows: 352 square miles south of U.S. Highway 26 and west of the South Fork John Day River.

(t) White River Wildlife Area: December 1 through March 31 annually — That part of the White River Unit as follows: 59 square miles along the eastern edge of the Mt. Hood National Forest in the southern half of the White River Unit;

(u) Lower Deschutes: Permanent Closure — That part of the Biggs Unit as follows: 12 square miles along lower 17 miles of Deschutes River except the county access road to Kloan;

(v) Murderers Creek-Flagtail: Three days prior to the opening of the archery deer and elk seasons through the close of controlled buck deer rifle season and from three days prior to the controlled Rocky Mountain bull elk first season through the Rocky Mountain bull elk second season — That part of the Murderers Creek Unit as follows: 185 square miles in Townships 13, 14, 15, 16, and 17 South, Ranges 26, 27, 28, and 29 East;

(w) Camp Creek: Three days prior to opening of controlled buck deer rifle season through the close of controlled buck deer rifle season and from three days prior to the controlled Rocky Mountain bull elk first season through the Rocky Mountain bull elk second season — That part of the Northside Unit as follows: 54 square miles in Townships 10, 11, and 12 South, Ranges 31, 32, and 33 East.

(x) Bridge Creek Wildlife Area: December 1 through April 14 annually except by permit: That part of the Ukiah Unit as follows: 20 square miles in Townships 5 and 6 south, Ranges 31 and 32 East in the Southwest corner of Ukiah Unit;

(y) Meacham: Three days prior to the opening of the archery deer and elk seasons through May 31. Approximately 41 square miles in Units 49, 52 and 54 in townships 1 and 2 south, township 1 north, ranges 34, 35, and 36 east.

(z) Dark Canyon: Three days prior to the opening of controlled buck deer season through the close of the last elk season encompassing this travel management area. That part of the Sumpter Unit as follows: 20 square miles in Townships 11 and 12 South, Ranges 40 and 41 East;

(aa) Patrick Creek: Three days prior to the opening of controlled buck deer season through the close of the last elk season and May 1 through June 30 encompassing this travel management area. That part of the Sumpter Unit as follows: 8 square miles in Townships 10 and 11 South, Ranges 35 1/2 and 36 East;

(bb) Dry Beaver/Ladd Canyon: Permanent Closure — That part of the Starkey Unit as follows: 125 square miles in Townships 4, 5 and 6 South, Ranges 35, 36, 37 and 38 East;

(cc) Clear Creek: Three days prior to opening of Rocky Mountain bull elk season through close of Rocky Mountain bull elk second season — That part of the Starkey Unit as follows: 21 square miles in Township 5 South, Ranges 37 and 38 East;

(dd) Trail Creek: Three days prior to opening of Rocky Mountain bull elk season through close of Rocky Mountain bull elk second season — That part of the Starkey Unit as follows: 29 square miles in Townships 6 and 7 South, Ranges 35 1/2 and 36 East;

(ee) Indian Creek-Gorham Butte: Three days prior to opening of Rocky Mountain bull elk season through close of Rocky Mountain bull elk second season — That part of the Starkey Unit as follows: 24 square miles in Townships 6 and 7 South, Ranges 36 and 37 East;

(ff) Elkhorn Wildlife Area: Permanent Closure — Those parts of the Starkey and Sumpter units as follows: 7 square miles in Township 6 South, Range 38 East;

(gg) Starkey Experimental Forest Enclosure: Permanent Closure — That part of the Starkey Unit as follows: 40 square miles in Townships 3 and 4 South, Range 34 East;

(hh) Hall Ranch: Three days prior to the opening of Rocky Mountain bull elk first season through April 30 — that part of the Catherine Creek Unit as follows: 3 square miles in Township 5 South, Range 41 East;

(ii) Little Catherine Creek: Three days prior to opening of archery season through May 31 — That part of the Catherine Creek Unit as follows: 22 square miles in Townships 3, 4 and 5 South, Ranges 40 and 41 East;

(jj) Walla Walla: Permanent Closure — Those parts of Walla Walla, Wenaha, and Mt. Emily units as follows: All gated, posted, and closed roads within the Walla Walla Ranger District of the Umatilla National Forest.

(kk) Wenaha Wildlife Area: Permanent Closure — That part of the Wenaha Unit as follows: 17 square miles in Townships 5 and 6 North, Ranges 42 and 43 East along eastern edge of Umatilla Forest in northeast corner of wenaha Unit;

(ll) Noregaard: Three days prior to archery season through May 31. However, roads will be open to permit removal of camping equipment during a time period extending through two Sundays following the end of the last antlerless elk rifle season. That part of the Sled Springs Unit as follows: 175 square miles in west one-third of Sled Springs Wildlife Unit.

(mm) Shamrock: Three days prior to archery season through May 31. However, roads will be open to permit removal of camping equipment during a time period extending through two Sundays following the end of the last antlerless elk rifle season. — That part of the Sled Springs Unit as follows: 20 square miles in Township 4 North, Range 44 East;

(nn) Chesnimnus: Three days prior to Chesnimnus rifle bull season through end of Chesnimnus rifle bull season — That portion of the Chesnimnus Wildlife Unit within the boundaries of the Wallowa-Whitman National Forest;

(oo) Cemetery Ridge Road: Permanent Closure — That part of the Chesnimnus Unit as follows: Cemetery Ridge Road north of the south boundary of Section 4, Township 3 North, and Range 48 East.

(pp) Lord Flat Trail (#1774): Three days prior to archery season through the end of all elk rifle seasons — 15 miles of road in Townships 1 South and 1 and 2 North, Ranges 49 and 50 East;

(qq) Grouse-Lick Creeks: Three days prior to opening of Rocky Mountain bull elk first season through the close of Rocky Mountain bull elk second season- That part of the Imnaha Unit as follows: 100 square miles in Townships 2, 3, 4, and 5 South, Ranges 46, 47 and 48 East;

(rr) Clear Lake Ridge: Three days prior to opening of archery season through December 1 annually — That part of the Imnaha Unit as follows: Five square miles in Township 2 South, Range 47 East, Sections 3 and 4 and Township 1 South, Range 47 East, Sections 28, 15, 33, 34 and 22.

(ss) Mehlorn: Permanent Closure: That part of the Pine Creek and Keating Units as follows: 26 square miles in Township 6 South, Ranges 45 and 46 East;

(tt) Lake Fork-Dutchman: Three days prior to opening of archery season to the end of all elk rifle seasons and from May 1 to July 1 — That part of the Pine Creek Unit as follows: 42 square miles in Townships 6 and 7 South, Ranges 46 and 47 East;

(uu) Okanogan-Fish: Three days prior to the opening of buck deer rifle season to the end of elk rifle seasons and from May 1 to July 1 — That part of the Pine Creek Unit as follows: 20 square miles in Township 6 and 7 South, Ranges 46 and 47 East;

(vv) Summit Point: Permanent Closure: That part of the Keating Unit as follows: 14 square miles in Townships 6 and 7 South, Ranges 44 and 45 East.

(ww) Eagle Creek: December 1 — April 15: That part of the Keating Unit as follows: 17 square miles in Townships 7 and 8 South, Range 44 and 45 East;

(xx) Conroy Cliff: Three days prior to the opening of controlled buck deer rifle season through the close of controlled buck deer rifle season and from three days prior to the controlled Rocky Mountain bull elk first season through the Rocky Mountain bull elk second season — That part of the Malheur River Unit as follows: 46 square miles in Townships 16, 17, and 18 South, Ranges 32 1/2, 34, and 35 East;

(yy) Devine Ridge-Rattlesnake: Three days prior to the opening of controlled buck deer rifle season through the close of controlled buck deer rifle season and from three days prior to the controlled Rocky Mountain bull elk first season through the Rocky Mountain bull elk second season — That part of the Malheur River Unit as follows: 59 square miles in Townships 20 and 21 South, Ranges 31, 32, 32 1/2 East;

(zz) Dairy Creek: Three days prior to the opening of controlled buck deer rifle season through the close of controlled buck deer rifle season and from three days prior to the controlled Rocky Mountain bull elk first season through the Rocky Mountain bull elk second season — That part of the Silvies Unit as follows: 98 square miles in Townships 19, 20, 21, and 22 South, Ranges 24, 25, and 26 East;

(aaa) Burnt Cabin: Three days prior to the opening of controlled buck deer rifle season through the close of controlled buck deer rifle season and from three days prior to the controlled Rocky Mountain bull elk first season through the Rocky Mountain bull elk second season — That part of the Silvies Unit as follows: 22 square miles in Townships 18 and 19 South, Ranges 26 and 27 East;

(bbb) Walker Rim; Three days prior to the opening of controlled buck deer season through the close of the controlled buck deer season — That part of the Fort Rock Unit as follows: 113 square miles in Townships 24, 25, and 26 South, Ranges 8, 9, and 10 East;

(ccc) North Paulina: Permanent Closure — That part of the Fort Rock Unit as follows: 12 square miles in Townships 25 and 26 South; Range 8 East;

(ddd) Sugarpine Mountain: Permanent Closure — That part of the Fort Rock Unit as follows: 40 square miles in Township 28, Ranges 9 and 10 East;

(eee) Stott Mt.-North Alsea: One day prior to opening of archery season through the bull elk rifle seasons — All gated and/or barrier closed roads within the Alsea Unit north of US Hwy 20 and west of State Hwy 223 (Kings Valley Hwy); and in the Stott Mt. Unit. Cooperators require: day use only on private lands, no ATV use on private lands and designated state lands, and no vehicle may block any road or gate. Access may be closed during extreme fire danger;

(fff) Spring Butte: Permanent Closure — That part of the Paulina Unit as follows: 30 square miles in Township 23 South, Range 11 East;

(ggg) Wildhorse Ridge/Teepee Butte: Three days prior to archery season through the end of all elk rifle seasons. Posted and gated roads north of 46 roads in Chesnimnus Unit are closed;

(hhh) Hells Canyon National Recreation Area: Permanent Closure — Those parts of the Chesnimnus, Imnaha, Snake River, and Pine Creek Units in Eastern Wallowa County that are closed by the National Recreation Area;

(iii) PO Saddle Road — Three days prior to opening of archery season through June 15th, annually — Three miles of road in Townships 3 and 4 South, Range 48 East.

(jjj) Whiskey Creek — Three days prior to archery season through May 31. However, roads will be open to permit removal of camping equipment during a time period extending through two Sundays following the last antlerless elk season. That part of the Sled Springs unit as follows — 45 square miles in Townships 2 and 3 North, Ranges 43, 44, and 45 East.

(kkk) South Boundary: Permanent Closure — That part of the Ochoco Unit as follows: 47 square miles in Townships 15 and 16 South, Ranges 20, 21, and 22 East.

(lll) Green Diamond Travel Management Area: Permanent Closure — Applies to all gated, posted, or barrier-closed roads within the Rogue, Keno, Klamath Falls, Sprague, Interstate, Silver Lake, and Fort Rock Units within the land holdings of Green Diamond Resource Company.

(mmm) Prineville Reservoir Wildlife Area: From November 15 or December 1 (as posted at each gate) through April 15 annually — That part of the Ochoco and Maury Units as follows: 5 square miles in Township 16 South, Range 17 East.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162

Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162

Hist.: FWC 123, f. & ef. 6-9-77; FWC 33-1978, f. & ef. 6-30-78; FWC 28-1979, f. & ef. 8-2-79; FWC 33-1980, f. & ef. 6-30-80; FWC 6-1981, f. & ef. 1-23-81; FWC 11-1981, f. & ef. 3-31-81; FWC 20-1981, f. & ef. 6-19-81; FWC 37-1982, f. & ef. 6-25-82; FWC 28, f. & ef. 7-8-83; FWC 34-1984, f. & ef. 7-24-84; FWC 43-1985, f. & ef. 8-22-85; FWC 35-1986, f. & ef. 8-7-86; FWC 15-1989, f. & cert. ef. 3-28-89; FWC 63-1989, f. & cert. ef. 8-15-89; FWC 24-1990, f. & cert. ef. 3-21-90; FWC 55-1990, f. & cert. ef. 6-21-90; FWC 58-1991, f. & cert. ef. 6-24-91; FWC 36-1993, f. & cert. ef. 6-14-93; FWC 18-1994, f. 3-30-94, cert. ef. 5-1-94; FWC 4-1995, f. 1-23-95, cert. ef. 7-1-95; FWC 30-1995, f. & cert. ef. 4-17-95; FWC 18-1996, f. 4-10-96, cert. ef. 8-1-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 5-2003, f. 1-17-03, cert. ef. 7-1-03; DFW 116-2003(Temp), f. & cert. ef. 11-25-03 thru 3-31-04; DFW 120-2003, f. 12-4-03, cert. ef. 6-16-04; DFW 125-2004, f. 12-21-04, cert. ef. 6-1-05; DFW 133-2005, f. 12-1-05, cert. ef. 6-1-06; DFW 128-2006, f. 12-7-06, cert. ef. 6-1-07; DFW 118-2007, f. 10-31-07, cert. ef. 1-1-08; DFW 150-

2008, f. 12-18-08, cert. ef. 1-1-09; DFW 168-2010, f. 12-29-10, cert. ef. 1-1-11; DFW 159-2011, f. 12-14-11, cert. ef. 1-1-12; DFW 147-2012, f. 12-18-12, cert. ef. 1-1-13; DFW 138-2013, f. & cert. ef. 12-20-13; DFW 159-2014(Temp), f. 12-4-14, cert. ef. 1-1-15 thru 6-29-15; DFW 69-2015, f. & cert. ef. 6-11-15; DFW 18-2016, f. & cert. ef. 3-21-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-065-0765
Tagging, Possession, Transportation and Evidence of Sex

(1) When the owner of any game mammal tag kills a game mammal for which a tag is issued, the owner shall immediately remove in its entirety only the month and day of kill and attach the tag in plain sight securely to the game mammal. The tag shall be kept attached to such carcass or remain with any parts thereof so long as the same are preserved.

(2) It is unlawful to have in possession any game mammal tag from which all or part of any date has been removed or mutilated except when the tag is legally validated and attached to a game mammal.

(3) It is unlawful to possess the meat or carcass of any deer, elk, pronghorn antelope, bighorn sheep, or Rocky Mountain goat without evidence of sex while in the field, forest, or in transit on any of the highways or premises open to the public in Oregon, except processed or cut and wrapped meat. Evidence of sex for deer, elk, pronghorn antelope, bighorn sheep, or Rocky Mountain goat is:

(a) The animal's scalp which shall include the attached eyes and ears, if animal is female; or ears, antlers or horns, and eyes if the animal is male, or;

(b) Reproductive organs (testicles, scrotum, or penis if male; vulva or udder (mammary) if female) naturally attached to one quarter of the carcass or to another major portion of meat.

(i) For hunts with antler or horn restrictions, if the head is not attached to the carcass, in addition to leaving the testicles, scrotum, or penis naturally attached to one quarter of the carcass or to another major portion of meat, the head or skull plate with both antlers or horns naturally attached shall accompany the carcass or major portions of meat.

(ii) For hunts where only white-tailed deer and for hunts where only mule deer are legal: in addition to evidence of sex, (testicles, scrotum, penis, vulva, udder, mammary), either the head or tail shall remain naturally attached to one quarter of the carcass or to another major portion of meat as evidence of the species taken.

(4) When any game mammal or part thereof is transferred to the possession of another person, a written record describing the game mammal or part being transferred indicating the name and address of the person whose tag was originally attached to the carcass and the number of that tag shall accompany such transfer and shall remain with such game mammal or part so long as the same is preserved or until replaced by a tag or seal of the Department.

(5) All game mammals in possession in the field or forest or in transit more than 48 hours after the close of the open season for such mammal must be tagged with a tag or metal seal by the Department or by the Oregon State Police.

(6) All game mammals or portions thereof shipped by commercial carrier shall be tagged with a tag or metal seal provided by the Department or by the Oregon State Police.

(7) It is unlawful to receive or have in possession any game mammal or part thereof which:

(a) Is not properly tagged;

(b) Was taken in violation of any wildlife laws or regulations; or

(c) Was taken by any person who is or may be exempt from the jurisdiction of such laws or regulations.

(8) No person shall possess any game mammal or part thereof which has been illegally killed, found or killed for humane reasons, except shed antlers, unless he has notified and received permission from the Department or personnel of the Oregon State Police prior to transporting.

(9) No person shall possess the horns of bighorn sheep or Rocky Mountain goat that were not taken legally during an authorized season. Any horns of bighorn sheep or Rocky Mountain goat obtained by the Department may be made available to scientific and educational institutions and for ceremonial purposes.

(10) Except for the following parts, importation of a cervid carcass or parts of a cervid carcass is prohibited if the cervid was killed in a state or province with a documented case of Chronic Wasting Disease:

(a) Meat that is cut and wrapped commercially or privately;

(b) Meat that has been boned out;

(c) Quarters or other portions of meat with no part of the spinal column or head attached;

(d) Hides and/or capes with no head attached;

(e) Skull plates with antlers attached that have been cleaned of all meat and brain tissue;

(f) Antlers with no tissue attached;

(g) Upper canine teeth (buglers, whistlers, ivories);

(h) Finished taxidermy heads.

(11) For the purposes of the parts and carcass import ban in subsection 10, the states or provinces with a documented case of Chronic Wasting Disease (CWD) are Alberta, Arkansas, Colorado, Illinois, Kansas, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Mexico, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming, and Saskatchewan. The Department shall add by temporary rule any additional states or provinces when any new cases of CWD arise.

(12) The parts and carcass import ban in subsection (11) does not apply to parts or carcasses shipped to the National Fish and Wildlife Forensics Laboratory (Ashland, Oregon) for the purpose of law enforcement investigations and also does not apply to parts or carcasses of reindeer/caribou.

(13) Cervid carcasses or parts of cervid carcasses found in Oregon in violation of the parts and carcass ban in subsection 10 shall be disposed of in a manner as follows:

(a) Brain tissue, spinal columns, and whole heads or heads minus the cleaned skull plate and attached antlers, shall be disposed of either by incineration at temperatures exceeding 800° F or at lined landfills registered by Oregon Department of Environmental Quality capable of accepting animal carcasses without environmental contamination; rendering is not an allowed means of disposal.

(b) The person(s) who imported parts in violation of the parts and carcass ban in subsection 10 shall pay for appropriate disposal of cervid carcasses or parts of cervid carcasses.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 123, f. & ef. 6-9-77; FWC 33-1978, f. & ef. 6-30-78; FWC 28-1979, f. & ef. 8-2-79; FWC 33-1980, f. & ef. 6-30-80; FWC 6-1981, f. & ef. 1-23-81; FWC 11-1981, f. & ef. 3-31-81; FWC 20-1981, f. & ef. 6-19-81; FWC 37-1982, f. & ef. 6-25-82; FWC 34-1984, f. & ef. 7-24-84; FWC 43-1988, f. & ef. 8-22-85; FWC 35-1986, f. & ef. 8-7-86; FWC 11-1987, f. & ef. 3-6-87; FWC 41-1987, f. & ef. 7-6-87; FWC 13-1988, f. & cert. ef. 3-10-88; FWC 63-1989, f. & cert. ef. 8-15-89; FWC 24-1990, f. & cert. ef. 3-21-90; FWC 9-1997, f. & cert. ef. 2-27-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 90-2002(Temp), f. & cert. ef. 8-16-02 thru 2-11-03; DFW 114-2002(Temp), f. & cert. ef. 10-18-02 thru 2-11-03; DFW 126-2002, f. & cert. ef. 11-12-02; DFW 127-2002(Temp), f. & cert. ef. 11-14-02 thru 2-11-03; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 61-2003, f. & cert. ef. 7-16-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 111-2005(Temp), f. & cert. ef. 9-23-05 thru 10-31-05; Administrative correction 11-18-05; DFW 128-2005, f. 12-1-05, cert. ef. 1-1-06; DFW 135-2008, f. & cert. ef. 10-17-08; DFW 2-2009, f. & cert. ef. 1-9-09; DFW 8-2010(Temp), f. & cert. ef. 1-25-10 thru 7-24-10; DFW 21-2010(Temp), f. & cert. ef. 2-26-10 thru 8-24-10; DFW 36-2010(Temp), f. & cert. ef. 3-30-10 thru 9-25-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 92-2012(Temp), f. & cert. ef. 7-23-12 thru 1-19-13; DFW 136-2012, f. & cert. ef. 10-24-12; DFW 137-2012(Temp), f. & cert. ef. 10-24-12 thru 4-22-13; DFW 4-2013, f. 1-15-13, cert. ef. 2-1-13; DFW 10-2013, f. & cert. ef. 2-7-13; DFW 138-2013, f. & cert. ef. 12-20-13; DFW 155-2014(Temp), f. & cert. ef. 10-28-14 thru 4-26-15; DFW 1-2015, f. & cert. ef. 1-6-15; DFW 69-2015, f. & cert. ef. 6-11-15; DFW 14-2016(Temp), f. & cert. ef. 2-25-16 thru 8-22-16; DFW 18-2016, f. & cert. ef. 3-21-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-066-0010
General Season Regulations

(1) Pursuant to ORS 497.112, annual black bear tag sales to nonresident black bear hunters for the general fall season shall be limited to no more than three percent of the total tag sales based on previous year's hunter densities.

(a) Tags shall be available at any authorized license agent and through the Salem Headquarters office on a first-come, first-served basis.

(b) The application procedure shall be as follows:

(A) An applicant may purchase a nonresident general black bear tag at any hunting license agent or;

(B) An applicant shall mail or fax copies, through the Salem Headquarters only, of his/her nonresident driver's license, adult nonresident hunting license, juvenile nonresident hunting license, or provide documentation which includes the following information:

(i) Applicant's full name and current address;

(ii) Applicant's date of birth;

(iii) Applicant's Social Security number;

(iv) Applicant's telephone number;

(c) An applicant shall include a fee of $15.50 (includes a $10.00 license agent fee) with the application.

(2) Open Area: The entire state is open, except that lands within one mile of the Rogue River between Grave Creek and Lobster Creek are closed to all black bear hunting. Nonresidents shall be restricted to hunting black bear only in specific areas as described below.

(3) Nonresident black bear tags shall be distributed by areas as described in the Black Bear Management Plan. These areas are described as follows:

(a) Northwest: All of wildlife management units: 10, 11, 12, 14, 15, 17, and 18.

(b) Southwest: All of wildlife management units: 20, 23, 24, 25, 26, 27, 28, and 29.

(c) Cascades: All of wildlife management units: 16, 19, 21, 22, 30, 31, 34, 39, 41, and 42 and those portions of wildlife management units 33 and 77 lying west of Highway 97.

(d) Eastern: All of wildlife management units: 32, 35, 38, 40, and 43 and those portions of wildlife management units 33 and 77 lying east of Highway 97; and all other wildlife management units to the east of these units.

(4) No person shall use dogs to hunt or pursue black bear.

(5) No person shall use bait to attract or hunt black bear.

(6) The skull of any bear taken must be presented to an ODFW office or designated collection site. The person who took the animal is responsible to have it presented, within 10 days of the kill, to be checked and marked. Skull must be unfrozen when presented for check-in. Check-in at ODFW offices must occur during normal business hours (8-5, Mon-Fri.). Hunters are required to check in the skull only, for the purpose of inspection, tagging and removal of a tooth for aging.

(7) When the bear skull is presented at check-in information that must be provided includes:

(a) Date of harvest and location of harvest including Wildlife Management Unit, and

(b) Complete hunter information including tag number as found on the bear tag; a completed "Wildlife Transfer Record Form" as found in the current year's Oregon Big Game Regulations is an alternative for providing the required information.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 118-2007, f. 10-31-07, c ert. ef. 1-1-08; DFW 150-2008, f. 12-18-08, cert. ef. 1-1-09; DFW 140-2009, f. 11-3-09, cert. ef. 1-1-10; DFW 142-2009, f. 11-12-09, cert. ef. 1-1-10; DFW 159-2011, f. 12-14-11, cert. ef. 1-1-12; DFW 147-2012, f. 12-18-12, cert. ef. 1-1-13; DFW 138-2013, f. & cert. ef. 12-20-13; DFW 81-2016, f. & cert. ef. 6-27-16

635-067-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods, and other restrictions for hunting pronghorn antelope, cougar, bighorn sheep, and Rocky Mountain goat pursuant to ORS Chapter 496.

(2) OAR chapter 635, division 067 incorporates, by reference, the requirements for hunting pronghorn antelope, cougar, bighorn sheep, and Rocky Mountain goat set out in the document entitled "2016 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2016 Oregon Big Game Regulations" in addition to OAR chapter 635, to determine all applicable requirements for hunting pronghorn antelope, cougar, bighorn sheep, and Rocky Mountain goat. The annual Oregon Big Game Regulations are available at authorized license agents and regional, district and headquarters offices and website of the Oregon Department of Fish and Wildlife.

(3) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

(4) Controlled hunt tags shall be issued by a controlled hunt drawing following the procedures established in OAR chapter 635, division 060. Permitted weapons and ammunition are established in OAR chapter 635, division 065. Controlled hunt tag numbers for 2016 and 2017 are listed in Tables 1, 2, and 3 and are adopted and incorporated into OAR chapter 635, division 067 by reference.

[ED. NOTE: Tables referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 65-1989, f. & cert. ef. 8-15-89; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 122-2004, f. 12-21-04, cert. ef. 1-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 128-2005, f. 12-1-05, cert. ef. 1-1-06; DFW 41-2006, f. & cert. ef. 6-14-06; DFW 127-2006, f. 12-7-06, cert. ef. 1-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 118-2007, f. 10-31-07, c ert. ef. 1-1-08; DFW 60-2008, f. & cert. 6-12-08; DFW 150-2008, f. 12-18-08, cert. ef. 1-1-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 140-2009, f. 11-3-09, cert. ef. 1-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 85-2010(Temp), f. & cert. ef. 6-21-10 thru 12-17-10; DFW 168-2010, f. 12-29-10, cert. ef. 1-1-11; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 159-2011, f. 12-14-11, cert. ef. 1-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 147-2012, f. 12-18-12, cert. ef. 1-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 138-2013, f. & cert. ef. 12-20-13; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 1-2015, f. & cert. ef. 1-6-15; DFW 69-2015, f. & cert. ef. 6-11-15; DFW 18-2016, f. & cert. ef. 3-21-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-068-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods and other restrictions for hunting western Oregon deer pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2016 and 2017 are listed in Tables 1 and 2 and are adopted and incorporated into OAR chapter 635, division 068 by reference.

(3) OAR chapter 635, division 068 incorporates, by reference, the requirements for hunting western Oregon deer set out in the document entitled "2016 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2016 Oregon Big Game Regulations" in addition to OAR chapter 635, to determine all applicable requirements for hunting western Oregon deer. The annual Oregon Big Game Regulations are available at authorized license agents and regional, district, and headquarters offices of the Oregon Department of Fish and Wildlife.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

[ED. NOTE: Tables & publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 39-1988, f. & cert. ef. 6-13-88; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001. f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 3-2003, f. 1-17-03, cert. ef. 1-20-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 121-2003, f. 12-4-03, cert. ef. 1-19-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 124-2004, f. 12-21-04, cert. ef. 3-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 131-2005, f. 12-1-05, cert. ef. 3-1-06; DFW 41-2006, f. & cert. ef. 6-14-06; DFW 125-2006, f. 12-4-06, cert. ef. 3-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 116-2007, f. 10-31-07, cert. ef. 3-1-08; DFW 60-2008, f. & cert. 6-12-08; DFW 13-2009, f. 2-19-09, cert. ef. 3-1-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 14-2010, f. 2-16-10, cert. ef. 3-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 14-2011, f. 2-15-11, cert. ef. 3-1-11; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 15-2012, f. 2-10-12, cert. ef. 3-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 14-2013, f. 2-15-13, cert. ef. 3-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 122-2013, f. & cert. ef. 10-25-13; DFW 16-2014, f. & cert. ef. 2-27-14; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 15-2015, f. & cert. ef. 2-26-15; DFW 69-2015, f. & cert. ef. 6-11-15: DFW 18-2016, f. & cert. ef. 3-21-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-069-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods and other restrictions for hunting eastern Oregon deer pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2016 and 2017 are listed in Tables 1 and 2 and are adopted and incorporated into OAR chapter 635, division 069 by reference.

(3) OAR chapter 635, division 069 incorporates, by reference, the requirements for hunting eastern Oregon deer set out in the document entitled "2016 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2016 Oregon Big Game Regulations" in addition to OAR chapter 635, to determine all applicable requirements for hunting eastern Oregon deer. The annual Oregon Big Game Regulations are available at hunting license agents and regional, district and headquarters offices and website of the Oregon Department of Fish and Wildlife.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 40-1988, f. & cert. ef. 6-13-88; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 32-1999(Temp), f. & cert. ef. 5-4-99 thru 10-31-99; DFW 34-1999(Temp), f. & cert. ef. 5-12-99 thru 10-31-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 20-2000(Temp), f. 4-12-00, cert. ef. 4-12-00 thru 6-30-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 7-2003, f. 1-17-03, cert. ef. 2-1-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 122-2003, f. 12-4-03, cert. ef. 2-2-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 123-2004, f. 12-21-04, cert. ef. 2-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 130-2005, f. 12-1-05, cert. ef. 2-1-06; DFW 41-2006, f. & cert. ef. 6-14-06; DFW 124-2006, f. 12-7-06, cert. ef. 2-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 117-2007, f. 10-31-07, cert. ef. 2-1-08; DFW 60-2008,

f. & cert. 6-12-08; DFW 8-2009, f. & cert. ef. 2-3-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 4-2010, f. 1-12-10, cert. ef. 2-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 7-2011, f. 1-31-11, cert. ef. 2-1-11; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 3-2012, f. 1-13-12, cert. ef. 2-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 4-2013, f. 1-15-13, cert. ef. 2-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 3-2014, f. & cert. ef. 1-22-14; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 15-2015, f. & cert. ef. 2-26-15; DFW 69-2015, f. & cert. ef. 6-11-15: DFW 18-2016, f. & cert. ef. 3-21-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-070-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods and other restrictions for hunting Cascade and Coast elk pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2016 and 2017 are listed in Table1 and are adopted and incorporated into OAR chapter 635, division 070 by reference.

(3) OAR chapter 635, division 070 incorporates, by reference, the requirements for hunting western Oregon elk set out in the document entitled "2016 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2016 Oregon Big Game Regulations" in addition to OAR Chapter 635, to determine all applicable requirements for hunting western Oregon elk. The annual Oregon Big Game Regulations are available at hunting license agents and regional, district and headquarters offices of the Oregon Department of Fish and Wildlife.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

[ED. NOTE: Tables referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 41-1988, f. & cert. ef. 6-13-88; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 9-2003(Temp), f. & cert. ef. 1-28-03 thru 6-16-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 119-2003, f. 12-4-03, cert. ef. 4-1-04; DFW 130-2003(Temp), f. & cert. ef. 12-24-03 thru 3-1-04; DFW 8-2004(Temp), f. & cert. ef. 2-2-04 thru 7-31-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 107-2004(Temp), f. & cert. ef 10-18-04 thru 11-27-04; DFW 131-2004, f. 12-21-04, cert. ef. 4-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 132-2005, f. 12-1-05, cert. ef. 4-1-06; DFW 41-2006, f. & cert. ef. 6-14-06; DFW 126-2006, f. 12-7-06, cert. ef. 4-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 115-2007, f. 10-31-07, cert. ef. 4-1-08; DFW 60-2008, f. & cert. 6-12-08; DFW 31-2009, f. 3-23-09, cert. ef. 4-1-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 22-2010, f. 3-1-10, cert. ef. 4-1-10; DFW 31-2010, f. 3-12-10, cert. ef. 4-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 22-2012, f. 3-14-12, cert. ef. 4-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 21-2013, f. 3-11-13, cert. ef. 4-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 19-2014, f. & cert. ef. 3-11-14; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 25-2015, f. & cert. ef. 4-8-15; DFW 69-2015, f. & cert. ef. 6-11-15; DFW 28-2016, f. & cert. ef. 4-6-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-071-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods and other restrictions for hunting Rocky Mountain elk pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2016 and 2017 are listed in Table1 and are adopted and incorporated in OAR chapter 635, division 071 by reference.

(3) OAR chapter 635, division 071 incorporates, by reference, the requirements for hunting Rocky Mountain elk set out in the document entitled "2016 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2016 Oregon Big Game Regulations" in addition to OAR chapter 635, to determine all applicable requirements for hunting Rocky Mountain elk. The annual Oregon Big Game Regulations are available at hunting license agents and regional, district and headquarters offices of the Oregon Department of Fish and Wildlife.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

[ED. NOTE: Tables referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 42-1988, f. & cert. ef. 6-13-88; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 9-2003(Temp), f. & cert. ef. 1-28-03 thru 6-16-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 1-2004(Temp), f. & cert. ef. 1-13-04 thru 7-9-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 105-2004(Temp), f. & cert. ef. 10-13-04 thru 11-15-04, Administrative correction 11-22-04; DFW 131-2004, f. 12-21-04, cert. ef. 4-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 132-2005, f. 12-1-05, cert. ef. 4-1-06; DFW 22-2006(Temp), f. & cert. ef. 4-7-06 thru 10-4-06; DFW 41-2006, f. & cert. ef. 6-14-06; DFW 126-2006, f. 12-7-06, cert. ef. 4-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 115-2007, f. 10-31-07, cert. ef. 4-1-08; DFW 60-2008, f. & cert. 6-12-08; DFW 31-2009, f. 3-23-09, cert. ef. 4-1-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 22-2010, f. 3-1-10, cert. ef. 4-1-10; DFW 31-2010, f. 3-12-10, cert. ef. 4-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 22-2012, f. 3-14-12, cert. ef. 4-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 21-2013, f. 3-11-13, cert. ef. 4-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 19-2014, f. & cert. ef. 3-11-14; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 25-2015, f. & cert. ef. 4-8-15; DFW 69-2015, f. & cert. ef. 6-11-15; DFW 28-2016, f. & cert. ef. 4-6-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-073-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas and other restrictions for bow and muzzleloader hunting, Premium Hunts, and controlled deer and elk youth hunts; pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2016 and 2017 for deer and elk bow and muzzleloader hunting and deer and elk youth hunts are listed in Tables 1, 2 and 3 and are adopted and incorporated into OAR chapter 635, division 073 by reference.

(3) OAR chapter 073 incorporates, by reference, the requirements for bow and muzzleloader hunting, Premium Hunts, and controlled deer and elk youth hunts set out in the document entitled "2016 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2016 Oregon Big Game Regulations," in addition to OAR chapter 635, to determine all applicable requirements for bow and muzzleloader hunting, Premium Hunts, and controlled deer and elk youth hunts. The annual Oregon Big Game Regulations are available at hunting license agents and regional, district and headquarters offices and website of the Oregon Department of Fish and Wildlife.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

(5) Notwithstanding the provisions of the 2016 Oregon Big Game Regulations: The following text on page 16 of the Regulations is inaccurate and is being replaced: Hunt area: Entire wildlife management unit, units, or parts of units indicated by the hunt name, or as described in 635-073-0100(3). See pages 106-109 of the 2016 Oregon Big Game Regulations for specific area closures.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 44-1988, f. & cert. ef. 6-13-88; FWC 18-1994, f. 3-30-94, cert. ef. 5-1-94; FWC 17-1996, f. 4-10-96, cert. ef. 4-15-96; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 21-2000(Temp), f. 4-12-00, cert. ef. 4-12-00 thru 6-30-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 3-2003, f. 1-17-03, cert. ef. 1-20-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 122-2003, f. 12-4-03, cert. ef. 2-2-04; DFW 130-2003(Temp), f. & cert. ef. 12-24-03 thru 3-1-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 123-2004, f. 12-21-04, cert. ef. 2-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 130-2005, f. 12-1-05, cert. ef. 2-1-06; DFW 22-2006(Temp), f. & cert. ef. 4-7-06 thru 10-4-06; DFW 41-2006, f. & cert. ef. 6-14-06; DFW 124-2006, f. 12-7-06, cert. ef. 2-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 117-2007, f. 10-31-07, cert. ef. 2-1-08; DFW 60-2008, f. & cert. 6-12-08; DFW 8-2009, f. & cert. ef. 2-3-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 4-2010, f. 1-12-10, cert. ef. 2-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 7-2011, f. 1-31-11, cert. ef. 2-1-11; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 3-2012, f. 1-13-12, cert. ef. 2-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 4-2013, f. 1-15-13, cert. ef. 2-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 3-2014, f. & cert. ef. 1-22-14; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 89-2014(Temp), f. & cert. ef. 7-7-14 thru 11-1-14; Administrative correction 11-24-14; DFW 15-2015, f. & cert. ef. 2-26-15; DFW 69-2015, f. & cert. ef. 6-11-15: DFW 18-2016, f. & cert. ef. 3-21-16; DFW 46-2016(Temp), f. & cert. ef. 5-10-16 thru 11-1-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-073-0100
Controlled Premium Hunt Regulations

(1) Tags shall be issued by a controlled hunt drawing following the procedures established in OAR chapter 635, division 060.

(2) "L" series Premium Hunt deer tags, "M" series Premium Hunt elk tags, and "N" series Premium Hunt pronghorn antelope tags are in addition to all other tags and permits approved by the commission.

(a) In addition to the number of deer, elk, and pronghorn antelope tags legally available to an individual, an individual is allowed one additional deer tag, one additional elk tag, and one additional pronghorn antelope tag annually provided these tags are Premium Hunt series tags.

(3)(a) N40 Maupin/W Biggs, same hunt area as hunt 440 on page 38 of the 2016 Oregon Big Game Regulations;

(b) N44 Columbia Basin/E Biggs, that part of unit 43 east of John Day River and unit 44;

(c) N70A E Beatys Butte, same hunt area as hunt 470A on page 38 of the 2016 Oregon Big Game Regulations;

(d) N70B W Beatys Butte, same hunt area as hunt 470B on page 38 of the 2016 Oregon Big Game Regulations and that part of Hart Mt National Antelope Refuge (NWR) within the Beatys Butte unit;

(e) N71 Juniper, unit 71 including that part of Hart Mt NWR within the Juniper unit, excluding that part of Malheur NWR north of Foster Flat Rd.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: DFW 18-2016, f. & cert. ef. 3-21-16; DFW 81-2016, f. & cert. ef. 6-27-16

635-075-0022
Landowner Hunting Preference Tags for Mule Deer

(1) This rule further implements HB 2027A whereby the 2013 Legislative Assembly directed the Department through the commission to specify a formula that bases the number of landowner preference tags available for mule deer on the management, research, and habitat needs set forth in the wildlife management plan for mule deer.

(2) For purposes of this rule, the population management objectives (MOs) for each wildlife management unit that were adopted by the commission in June 2005 are considered representative of the management, research, and habitat needs for mule deer.

(3) The formula to determine the number of landowner hunting preference tags available for buck deer in a unit is as follows:

(a) In those wildlife management units where the estimated mule deer population is less than 100% of the established population management objective, the number of landowner hunting preference tags available for buck deer in that unit may be limited to five tags or 10 percent of the total controlled buck tags authorized for the public for each hunt in that unit by the commission, whichever is greater.

(b) In those wildlife management units where the estimated mule deer population is equal to or more than 100% of the established population management objective, the number of landowner hunting preference tags available for buck deer in that unit may be issued based upon a landowner's acreage as set forth in 635-075-0005 (8).

(4) For the purposes of OAR 635-075-0022(3), "qualified landowner" is a landowner who registered their land through the landowner preference program for the Wildlife Management Unit which includes the controlled hunt and who has a current tag distribution form filed with the Department.

(5) Landowner Hunting Preference Tag numbers for mule deer in 2016 and 2017 are listed in **Table 1** and are adopted and incorporated in OAR chapter 635, division 075 by reference.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: DFW 1-2015, f. & cert. ef. 1-6-15; DFW 69-2015, f. & cert. ef. 6-11-15; DFW 81-2016, f. & cert. ef. 6-27-16

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Rule Caption: Spring Chinook Fisheries Close In the Imnaha River.
Adm. Order No.: DFW 82-2016(Temp)
Filed with Sec. of State: 6-27-2016
Certified to be Effective: 7-3-16 thru 8-31-16
Notice Publication Date:
Rules Amended: 635-019-0090
Rules Suspended: 635-019-0090(T)
Subject: This amended rule closes the recreational spring Chinook fishery on the Imnaha River at 11:59 p.m. Sunday, July 3, 2016. The harvest guideline for the fishery is expected to be attained by that time.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-019-0090
Inclusions and Modifications

(1) The **2016 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 **2016 Oregon Sport Fishing Regulations**.

(2) 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 June 15, 2016 through July 3, 2016.

(a) 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 is met.

(b) Statewide hook regulations apply: Single point hooks larger than 1 inch gap and multiple point hooks larger than 9/16 inch gap are prohibited.

(c) All other General, Statewide and Northeast Zone Regulations, as provided in the **2016 Oregon Sport Fishing Regulations**, remain in effect.

(3) The Wallowa River from a deadline at the lower end of Minam State Park upstream to the confluence with the Lostine River is open to angling for adipose fin-clipped adult Chinook salmon from July 2, 2016 until further notice.

(a) 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 is met.

(b) Statewide hook regulations apply: Single point hooks larger than 1 inch gap and multiple point hooks larger than 9/16 inch gap are prohibited.

(c) All other General, Statewide and Northeast Zone Regulations, as provided in the **2016 Oregon Sport Fishing Regulations**, remain in effect.

Stat. Auth.: ORS 496.138, 496.146, 506.119
Stats. Implemented: ORS 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; Administrative correction 11-1-13; DFW 121-2013(Temp), f. 10-24-13, cert. ef. 11-1-13 thru 12-31-13; DFW 137-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 42-2014(Temp), f. 5-12-14, cert. ef. 5-17-14 thru 6-1-14; DFW 47-2014(Temp), f. 5-27-14, cert. ef. 5-31-14 thru 7-31-14; DFW 53-2014(Temp), f. 5-28-14, cert. ef. 6-1-14 thru 7-31-14; DFW 58-2014(Temp), f. 6-9-14, cert. ef. 6-21-14 thru 8-31-14; DFW 71-2014(Temp), f. 6-16-14, cert. ef. 6-18-14 thru 9-1-14; DFW 72-2014(Temp), f. & cert. ef. 6-19-14 thru 9-1-14; DFW 75-2014(Temp), f. 6-23-14, cert. ef. 6-27-14 thru 9-1-14; DFW 82-2014(Temp), f. 7-1-14, cert. ef. 7-5-14 thru 9-1-14; DFW 86-2014(Temp), f. 7-2-14, cert. ef. 7-5-14 thru 9-1-14; DFW 97-2014(Temp), f. 7-18-14, cert. ef. 7-21-14 thru 9-30-14; Administrative correction, 10-24-14; DFW 165-2014, f. 12-18-14, cert. ef. 1-1-15; DFW 45-2015(Temp), f. 5-15-15, cert. ef. 5-20-15 thru 6-30-15; DFW 53-2015(Temp), f. 5-27-15, cert. ef. 6-6-15 thru 8-31-15; DFW 64-2015(Temp), f. & cert. ef. 6-9-15 thru 8-31-15; DFW 81-2015(Temp), f. 7-1-15, cert. ef. 7-5-15 thru 8-31-15; DFW 88-2015(Temp), f. 7-16-15, cert. ef. 7-18-15 thru 12-31-15; DFW 99-2015(Temp), f. & cert. ef. 8-3-15 thru 12-31-15; DFW 121-2015(Temp), f. 8-31-15, cert.

ef. 9-1-15 thru 12-31-15; DFW 167-2015, f. 12-29-15, cert. ef. 1-1-16; DFW 45-2016(Temp), f. 5-5-16, cert. ef. 5-10-16 thru 6-5-16; DFW 54-2016(Temp), 5-23-16, cert. ef. 5-18-16 thru 6-5-16; DFW 62-2016(Temp), f. 6-1-16, cert. ef. 6-15-16 thru 8-31-16; DFW 80-2016(Temp), f. 6-24-16, cert. ef. 7-2-16 thru 8-31-16; DFW 82-2016(Temp), f. 6-27-16, cert. ef. 7-3-16 thru 8-31-16

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Rule Caption: In-season Adjustments to Trip Limits for the Commercial Nearshore and Sablefish Fisheries.
Adm. Order No.: DFW 83-2016(Temp)
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-5-16 thru 12-31-16
Notice Publication Date:
Rules Amended: 635-004-0275, 635-004-0355
Subject: These amended rules implement in-season trip limit adjustments for the Oregon commercial nearshore fishery, and adopt federal in-season decreases to sablefish trip limits. Federal in-season decreases are adopted by reference in Oregon's administrative rules. Black rockfish trip limits will be increased from 1,600 to 2,400 pounds in period 4, from 1,400 to 2,200 pounds in period 5, and from 1,000 to 1,800 pounds in period 6. In addition, 2016 trip limits for blue rockfish increased from 30 to 50 pounds. Other nearshore rockfish increased from 200 to 350 pounds, and greenling from 400 to 600 pounds for periods 4, 5 and 6.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-004-0275
Scope, Inclusion, and Modification of Rules

(1) The commercial groundfish 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 groundfish. 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, Subparts C, D, E and F (October 1, 2015 ed.) as amended;

(b) Federal Register Vol. 80, No. 46, dated March 10, 2015 (80 FR 12567);

(c) Federal Register Vol. 80. No. 222, dated November 18, 2015 (80 FR 71975);

(d) Federal Register Vol. 80. No. 239, dated December 14, 2015 (80 FR 77267.

(2) Persons must consult the federal regulations in addition to Division 004 to determine all applicable groundfish 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 635-004-0280 through 635-004-0365 for additions or modifications to federal groundfish regulations.

(4) Notwithstanding the regulations defined in section (1) of this rule, the National Marine Fisheries Service, by means of Federal Register Vol. 81, No. 124, dated Tuesday, June 28, 2016 (81 FR 41868), announced inseason actions and management measures effective June 28, 2016, including but not limited to decreases to sablefish trip limits in the Limited Entry Fixed Gear and Open Access Sablefish Daily Trip Limit Fisheries.

[Publications: Publications referenced are available from the Department.]
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 78-2012(Temp), f. 6-28-12, cert. ef. 7-1-12 thru 10-27-12; DFW 106-2012(Temp), f. 8-15-12, cert. ef. 9-1-12 thru 12-31-12; DFW 1-2013, f. & cert. ef. 1-3-13; DFW 96-2013(Temp), f. 8-27-13, cert. ef. 9-1-13 thru 12-31-13; DFW 132-2013(Temp), f. & cert. ef. 12-9-13 thru 6-7-14; DFW 136-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 34-2014(Temp), f. & cert. ef. 4-23-14 thru 9-30-14; DFW 109-2014(Temp), f. & cert. ef. 8-4-14 thru 12-31-14; DFW 163-2014(Temp), f. 12-15-14, cert. ef. 1-1-15 thru 6-29-15; DFW 18-2015, f. & cert. ef. 3-10-15; DFW 68-2015(Temp), f. 6-11-15, cert. ef. 6-12-15 thru 12-8-15; DFW 111-2015(Temp), f. & cert. ef. 8-19-15 thru 2-14-16; DFW 151-2015(Temp), f. & cert. ef. 11-2-15 thru 4-29-16; DFW 159-2015(Temp), f. & cert. ef. 11-25-15 thru 5-22-16; DFW 3-2016, f. & cert. ef. 1-19-16; DFW 83-2016(Temp), f. 6-29-16, cert. ef. 7-5-16 thru 12-31-16

635-004-0355
Trip Limits

(1) The trip limits outlined in this rule are set at the beginning of each calendar year based on commercial harvest caps and projected fishing effort, and are subject to in-season adjustments and closures. Fishers should refer to Nearshore Commercial Fishery Industry Notices on the Marine Resources Program Commercial Fishing Rules and Regulations webpage for the most up-to-date information regarding trip limits and other regulations affecting the Nearshore Commercial Fishery.

(2) Vessels with a Black Rockfish/Blue Rockfish/Nearshore Fishery Permit, with or without a Nearshore Endorsement, may land no more than the following cumulative trip limits:

(a) Black rockfish:

(A) 1200 pounds in period 1;

(B) 1400 pounds in period 2;

(C) 1700 pounds in period 3;

(D) 2,400 in period 4;

(E) 2,200 pounds in period 5; and

(F) 1,800 pounds in period 6.

(b) 50 pounds of blue rockfish and deacon rockfish combined in each period.

(3) For all other nearshore species, vessels with a Black Rockfish/Blue Rockfish/Nearshore Fishery Permit with Nearshore Endorsement may land no more than the following cumulative trip limits in each period:

(a) 350 pounds of other nearshore rockfish combined;

(b) 1,500 pounds of cabezon; and

(c) 600 pounds of greenling species.

Stat. Auth.: ORS 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 75-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 79-2012(Temp), f. 6-28-12, cert. ef. 7-1-12 thru 12-27-12; DFW 118-2012(Temp), f. 9-10-12, cert. ef. 9-11-12 thru 12-31-12; DFW 141-2012(Temp), f. 10-31-12, cert. ef. 11-1-12 thru 12-31-12; DFW 151-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 99-2013(Temp), f. & cert. ef. 9-9-13 thru 12-31-13; Administrative correction, 2-5-14; DFW 101-2014(Temp), f. 7-23-14, cert. ef. 8-1-14 thru 12-31-14; DFW 147-2014(Temp), f. & cert. ef. 10-13-14 thru 12-31-14; DFW 164-2014(Temp), f. 12-15-14, cert. ef. 1-1-15 thru 1-16-15; DFW 4-2015, f. 1-13-15, cert. ef. 1-15-15; DFW 82-2015(Temp), f. 7-1-15, cert. ef. 7-5-15 thru 12-31-15; DFW 114-2015(Temp), f. 8-27-15, cert. ef. 9-1-15 thru 12-31-15; Administrative correction, 1-22-16; DFW 3-2016, f. & cert. ef. 1-19-16; DFW 83-2016(Temp), f. 6-29-16, cert. ef. 7-5-16 thru 12-31-16

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Rule Caption: Commercial Sardine Fishery Requirements for 2016-2017.
Adm. Order No.: DFW 84-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16 thru 11-30-16
Notice Publication Date:
Rules Amended: 635-004-0375
Subject: This amended rule modifies Oregon's commercial sardine fisheries and brings the State of Oregon concurrent with federally adopted regulations. Modifications establish 2016–17 sardine harvest guidelines and incidental landing allowances for Oregon's commercial fisheries.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-004-0375
Scope, Inclusion, and Modification of Rules

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, 2013 ed.); and

(b) Federal Register Vol. 81, No. 122, dated June 24, 2016 (81 FR 41251).

(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; DFW 90-2013(Temp), f. 8-20-13, cert. ef. 8-22-13 thru 9-14-13; DFW 76-2014(Temp), f. 6-24-14, cert. ef. 6-25-14 thru 7-31-14; DFW 99-2014, f. 7-21-14, cert. ef. 7-22-14 thru 9-30-14; DFW 104-2014(Temp), f. 7-29-14, cert. ef. 8-1-14 thru 9-30-14; DFW 114-2014, f. & cert. ef. 8-5-14; Suspended by DFW 129-2014(Temp), f. 9-10-14, cert. ef. 9-15-14 thru 9-30-14; DFW 136-2014(Temp), f. 9-19-14, cert. ef. 9-20-14 thru 12-31-14; Administrative correction, 1-27-15; DFW 30-2015(Temp), f. 4-22-15, cert. ef. 4-25-15 thru 6-30-15; DFW 47-2015(Temp), f. 5-21-15, cert. ef. 5-27-15 thru 11-22-15; DFW 77-2015, f. & cert. ef. 6-29-15; DFW 78-2015(Temp), f. & cert. ef. 6-29-15 thru 12-25-15; Administrative correction, 1-22-16; DFW 84-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 11-30-16

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Rule Caption: Commercial Salmon and Shad Fishing Periods Authorized for Columbia River Select Areas.
Adm. Order No.: DFW 85-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 6-30-16 thru 7-31-16
Notice Publication Date:
Rules Amended: 635-042-0160, 635-042-0170
Rules Suspended: 635-042-0160(T), 635-042-0170(T)
Subject: This amended rule adds two new 12-hour fishing periods in both the Blind and Knappa sloughs, and in the Tongue Point/South Channel commercial salmon fisheries of the Columbia River Select Areas. Modifications are consistent with action taken June 30, 2016 by the Oregon and Washington Departments of Fish and Wildlife at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-042-0160
Blind Slough and Knappa Slough Select Area Salmon Season

(1) Salmon and shad may be taken for commercial purposes during open 2016 fishing periods described as the winter fishery and the spring fishery in subsections (1)(a)(A) and (1)(a)(B) respectively, of this rule in those waters of Blind Slough and Knappa Slough. Retention and sale of white sturgeon is prohibited. Retention and sales of non-adipose finclipped Chinook salmon from the Blind Slough Select area is prohibited from 12:00 noon through midnite on March 29, 2016. The following restrictions apply:

(a) The open fishing periods are established in segments categorized as the winter fishery in Blind Slough and Knappa Slough in subsection (1)(a)(A), the winter fishery in Blind Slough only in subsection (1)(a)(B), and the spring fishery in Blind Slough and Knappa Slough in subsection (1)(a)(C). The seasons are open nightly from 7:00 p.m. to 7:00 a.m. the following morning (12 hours), as follows:

(A) Blind Slough and Knappa Slough:

Monday, Wednesday and Thursday nights beginning Monday, February 8 through Friday, March 11 (15 nights);

Monday, March 14 (1 night); and Thursday, March 17 (1 night).

(B) Blind Slough Only: Monday and Thursday nights beginning Monday, March 21 through Tuesday, March 29 (3 nights).

(C) Blind Slough and Knappa Slough from 7:00 p.m. Thursday, June 30, 2016 to 7:00 a.m. the following morning (12 hours); and 7:00 p.m. Tuesday, July 5, 2016 to 7:00 a.m. the following morning (12 hours).

(b) The fishing areas for the winter and spring seasons are:

(A) Blind Slough are those waters from markers at the mouth of Blind Slough upstream to markers at the mouth of Gnat Creek which is located approximately 1/2 mile upstream of the county road bridge.

(B) Knappa Slough are all waters bounded by a line from the northerly most marker at the mouth of Blind Slough westerly to a marker on Karlson Island downstream to a north-south line defined by a marker on the eastern end of Minaker Island to markers on Karlson Island and the Oregon shore.

(C) During the period from May 2 through June 14, the Knappa Slough fishing area extends downstream to the boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon shore.

(c) Gear restrictions are as follows:

(A) During the winter and spring fisheries, outlined above in subsections (1)(a)(A), (1)(a)(B), and (1)(a)(C), gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. The attachment of additional weight and/or anchors directly to the lead line is permitted.

(B) It is unlawful to use a gill net having a mesh size that is less than 7-inches during the winter fishery or greater than 9.75-inches during the spring fishery.

(C) Nets not specifically authorized for use in these areas may be onboard a 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. Oregon licenses are required in the open waters upstream from the railroad bridge.

Stat. Auth.: ORS 183.325, 506.109 & 506.119

Stats. Implemented: ORS 506.129 & 507.030

Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998(Temp), f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 65-2000(Temp) f. 9-22-00, cert. ef. 9-25-00 thru 12-31-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 86-2001, f. & cert. ef. 9-4-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 14-2002(Temp), f. 2-13-02, cert. ef. 2-18-02 thru 8-17-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 16-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 16-2006(Temp), f. 3-23-06 & cert. ef. 3-26-06 thru 7-27-06; DFW 18-2006(Temp), f. 3-29-06, cert. ef. 4-2-06 thru 7-27-06; DFW 20-2006(Temp), f. 4-7-06, cert. ef. 4-9-06 thru 7-27-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06; DFW 75-2006(Temp), f. 8-8-06, cert. ef. 9-5-06 thru 12-31-06; DFW 92-2006(Temp), f. 9-1-06, cert. ef. 9-5-06 thru 12-31-06; DFW 98-2006(Temp), f. & cert. ef. 9-12-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; 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 13-2007(Temp), f. & cert. ef. 3-6-07 thru 9-1-07; DFW 25-2007(Temp), f. 4-17-07, cert. ef. 4-18-07 thru 7-26-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative correction 1-24-08; DFW 6-2008(Temp), f. 1-29-08, cert. ef. 1-31-08 thru 7-28-08; DFW 16-2008(Temp), f. 2-26-08, cert. ef. 3-2-08 thru 8-28-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert . ef. 8-1-08 thru 12-31-08; DFW 103(Temp), f. 8-26-08, cert. ef. 9-2-08 thru 10-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 49-2009(Temp), f. 5-14-09, cert. ef 5-17-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 15-2010(Temp), f. 2-19-10, cert. ef. 2-21-10 thru 6-11-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. & cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 44-2011(Temp), f. & cert. ef. 5-11-11 thru 6-10-11; Administrative correction 6-28-11; DFW 113-2011(Temp), f. 8-10-11, cert. ef. 8-15-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 12-2012(Temp), f. 2-8-12, cert. ef. 2-12-12 thru 7-31-12; DFW 104-2012(Temp), f. 8-6-12, cert. ef. 8-13-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef. 2-11-13 thru 7-31-13; DFW 24-2013(Temp), f. & cert. ef. 3-21-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 91-2013(Temp), f. 8-22-13, cert. ef. 8-26-13 thru 10-31-13; DFW 110-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 115-2014(Temp), f. 8-5-14, cert. ef. 8-18-14 thru 10-31-14; DFW 135-2014(Temp), f & cert. ef. 9-19-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 29-2015(Temp), f. & cert. ef. 4-21-15 thru 7-30-15; DFW 37-2015(Temp), f. 5-1-15, cert. ef. 5-4-15 thru 7-30-15; DFW 70-2015(Temp), f. 6-15-15, cert. ef. 6-16-15 thru 7-31-15; DFW 76-2015(Temp), f. 6-23-15, cert. ef. 6-25-15 thru 7-31-15; DFW 102-2015(Temp), f. 8-10-15, cert. ef. 8-17-15 thru 10-31-15; Administrative correction, 11-20-15; DFW 8-2016(Temp), f. 2-1-16, cert. ef. 2-8-16 thru 7-31-16; DFW 23-2016(Temp), f. & cert. ef. 3-28-16 thru 7-31-16; DFW 32-2016(Temp), f. 4-20-16, cert. ef. 4-21-16 thru 7-31-16; DFW 71-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 78-2016(Temp), f. 6-23-16 thru 7-31-16; DFW 85-2016(Temp), f. & cert. ef. 6-30-16 thru 7-31-16

635-042-0170
Tongue Point Basin and South Channel

(1) Tongue Point includes all waters bounded by a line extended from the upstream (southern most) pier (#1) at the Tongue Point Job Corps facility through navigation marker #6 to Mott Island, a line from a marker at the southeast end of Mott Island northeasterly to a marker on the northwest tip of Lois Island, and a line from a marker on the southwest end of Lois Island westerly to a marker on the Oregon shore.

(2) South Channel area includes all waters bounded by a line from a marker on John Day Point to a marker on the southwest end of Lois Island upstream to an upper boundary line from a marker on Settler Point northwesterly to the flashing red USCG marker #10, northwesterly to a marker on the eastern tip of Burnside Island defining the upstream terminus of South Channel.

(3) Salmon and shad may be taken for commercial purposes in those waters of Tongue Point and South Channel as described in section (1) and section (2) of this rule. Retention and sale of white sturgeon is prohibited. The 2016 open fishing periods are:

(a) Winter Season:

Monday and Thursday nights from 7:00 p.m. to 7:00 a.m. the following morning (12 hours) beginning Monday, February 8 through Friday, March 11 (10 nights).

(b) Spring Season:

From 7:00 p.m. Thursday, June 30, 2016 to 7:00 a.m. the following morning (12 hours); and

From 7:00 p.m. Tuesday, July 5, 2016 to 7:00 a.m. the following morning (12 hours).

(4) Gear restrictions are as follows:

(a) In waters described in section (1) as Tongue Point basin, gill nets may not exceed 250 fathoms in length and weight limit on the lead line is not to exceed two pounds on any one fathom. It is unlawful to use a gill net having a mesh size that is less than 7 inches during the winter season or more than 9.75-inches during the spring season.

(b) In waters described in section (2) as South Channel, nets are restricted to 250 fathoms in length with no weight restrictions on the lead line. The attachment of additional weight and/or anchors directly to the lead line is permitted. It is unlawful to use a gill net having a mesh size that is less than 7 inches during the winter season or more than 9.75 inches during the spring season.

(c) Nets not specifically authorized for use in these areas may be onboard a 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.

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; FWC 61-1997(Temp), f. 9-23-97, cert. ef. 9-24-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 41-1998(Temp), f. 5-28-98, cert. ef. 5-29-98; DFW 42-1998(Temp), f. 5-29-98, cert. ef. 5-31-98 thru 6-6-98; DFW 45-1998(Temp), f. 6-5-98, cert. ef. 6-6-98 thru 6-10-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998, f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; Administrative correction 7-30-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 76-2006(Temp), f. 8-8-06, cert. ef. 9-5-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative Correction 1-24-08; DFW 44-2008(Temp), f. 4-25-08, cert. ef. 4-28-08 thru 10-24-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert. ef. 8-1-08 thru 12-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 29-2010(Temp), f. 3-9-10, cert. ef. 4-19-10 thru 6-12-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. & cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 44-2011(Temp), f. & cert. ef. 5-11-11 thru 6-10-11; Administrative correction 6-28-11; DFW 113-2011(Temp), f. 8-10-11, cert. ef. 8-15-11 thru 10-31-11; DFW 122-2011(Temp), f. 8-29-11, cert. ef. 9-19-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 41-2012(Temp), f. 4-24-12, cert. ef. 4-26-12 thru 6-30-12; Administrative correction, 8-1-12; DFW 104-2012(Temp), f. 8-6-12, cert. ef. 8-13-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef. 2-11-13 thru 7-31-13; DFW 34-2013(Temp), f. 5-14-13, cert. ef. 5-15-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 91-2013(Temp), f. 8-22-13, cert. ef. 8-26-13 thru 10-31-13; DFW 110-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 115-2014(Temp), f. 8-5-14, cert. ef. 8-18-14 thru 10-31-14; DFW 135-2014(Temp), f & cert. ef. 9-19-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 29-2015(Temp), f. & cert. ef. 4-21-15 thru 7-30-15; DFW 37-2015(Temp), f. 5-1-15, cert. ef. 5-4-15 thru 7-30-15; DFW 102-2015(Temp), f. 8-10-15, cert. ef. 8-17-15 thru 10-31-15; Administrative correction, 11-20-15; DFW 8-2016(Temp), f. 2-1-16, cert. ef. 2-8-16 thru 7-31-16; DFW 32-2016(Temp), f. 4-20-16, cert. ef. 4-21-16 thru 7-31-16; DFW 71-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 78-2016(Temp), f. 6-23-16 thru 7-31-16; DFW 85-2016(Temp), f. & cert. ef. 6-30-16 thru 7-31-16

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Rule Caption: Treaty Indian Commercial Summer Salmon Fisheries Set.
Adm. Order No.: DFW 86-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-5-16 thru 8-31-16
Notice Publication Date:
Rules Amended: 635-041-0076
Rules Suspended: 635-041-0076(T)
Subject: This amended rule authorizes the sales of fish caught in two 3-and-a-half day Treaty Indian commercial salmon gillnet fisheries above Bonneville Dam in the Columbia River. The first fishing period begins at 6:00 a.m. Tuesday, July 5 and the second period begins at 6:00 a.m. Monday, July 11. Modifications are consistent with action taken June 30, 2016 by the Departments of Fish and Wildlife for the States of Oregon and Washington in cooperation with the Columbia River Treaty Tribes at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-041-0076
Summer Salmon Season

(1) Salmon, steelhead, shad, walleye, catfish, bass, yellow perch, and carp may be taken for commercial purposes from Zone 6, in the Columbia River Treaty Indian fishery, from 6:00 a.m. Thursday, June 16 through 11:59 p.m. Sunday, July 31, 2016. Fish caught during any open period may be sold after the period concludes.

(a) White sturgeon between 38–54 inches in fork length caught in the Bonneville Pool and between 43–54 inches in fork length caught in The Dalles Pool and John Day pools may not be sold but may be retained for subsistence use.

(b) Gear is restricted to subsistence fishing gear which includes hoopnets, dipnets, and rod and reel with hook-and-line, with the following exceptions:

(A) Fish may be taken by gill nets with no mesh size restrictions during the following periods: from 6:00 a.m. Monday, July 18 through 6:00 p.m. Friday, July 22 (4.5 days); and

(B) Fish may be taken by gill nets with no mesh size restrictions during the following periods: from 6:00 a.m. Monday, July 25 through 6:00 p.m. Friday, July 29 (4.5 days).

(c) Closed areas as set forth in OAR 635-041-0045 remain in effect with the exception of Spring Creek Hatchery sanctuary.

(2) Effective 6:00 a.m. Thursday, June 16 through 11:59 p.m. Sunday, July 31, 2016, commercial sales of salmon, steelhead, walleye, shad, catfish, carp, bass and yellow perch caught in Yakama Nation tributary fisheries in the Klickitat River, Wind River, Drano Lake, Icicle Creek and Yakima River are allowed for Yakama Nation members during those days and hours when these tributaries are open under lawfully enacted Yakama Nation fishing periods.

(a) Sturgeon between 38–54 inches in fork length harvested in tributaries within Bonneville Pool may not be sold but may be kept for subsistence purposes.

(b) Gear is restricted to subsistence fishing gear which includes hoop nets, bag nets, dip nets, and rod and reel with hook-and-line. Gillnets may only be used in Drano Lake.

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; DFW 77-2013(Temp), f. 7-18-13, cert. ef. 7-22-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 66-2014(Temp), f. 6-12-14, cert. ef. 6-16-14 thru 7-31-14; DFW 79-2014(Temp), f. 6-26-14, cert. ef. 6-30-14 thru 7-31-14; DFW 91-2014(Temp), f. 7-10-14, cert. ef. 7-14-14 thru 7-31-14; DFW 95-2014(Temp), f. 7-17-14, cert. ef. 7-21-14 thru 7-31-14; DFW 103-2014(Temp), f.7-23-14, cert. ef. 7-28-14 thru 7-31-14; Administrative correction, 8-28-14; DFW 71-2015(Temp), f. 6-15-15, cert. ef. 6-16-15 thru 7-31-15; DFW 80-2015(Temp), f. 6-30-15, cert. ef. 7-6-15 thru 7-31-15; DFW 83-2015(Temp), f. 7-7-15, cert. ef. 7-8-15 thru 7-31-15; DFW 87-2015(Temp), f. & cert. ef. 7-15-15 thru 7-31-15; DFW 90-2015(Temp), f. 7-20-15, cert. ef. 7-21-15 thru 7-31-15; DFW 93-2015(Temp), f. 7-27-15, cert. ef. 7-28-15 thru 7-31-15; Administrative correction, 8-18-15; DFW 70-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 86-2016(Temp), f. 6-30-16, cert. ef. 7-5-16 thru 8-31-16

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Rule Caption: Commercial Salmon and Shad Fishing Periods Authorized for Columbia River Select Areas.
Adm. Order No.: DFW 87-2016(Temp)
Filed with Sec. of State: 7-7-2016
Certified to be Effective: 7-7-16 thru 7-31-16
Notice Publication Date:
Rules Amended: 635-042-0160, 635-042-0170
Rules Suspended: 635-042-0160(T), 635-042-0170(T)
Subject: This amended rule adds two new 12-hour commercial salmon fishing periods to both the Blind and Knappa sloughs and the Tongue Point/South Channel Select Area fisheries on the Columbia River. Modifications are consistent with action taken July 6, 2016 by the Oregon and Washington Departments of Fish and Wildlife at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-042-0160
Blind Slough and Knappa Slough Select Area Salmon Season

(1) Salmon and shad may be taken for commercial purposes during open 2016 fishing periods described as the winter fishery and the spring fishery in subsections (1)(a)(A) and (1)(a)(B) respectively, of this rule in those waters of Blind Slough and Knappa Slough. Retention and sale of white sturgeon is prohibited. Retention and sales of non-adipose finclipped Chinook salmon from the Blind Slough Select area is prohibited from 12:00 noon through midnite on March 29, 2016. The following restrictions apply:

(a) The open fishing periods are established in segments categorized as the winter fishery in Blind Slough and Knappa Slough in subsection (1)(a)(A), the winter fishery in Blind Slough only in subsection (1)(a)(B), and the spring fishery in Blind Slough and Knappa Slough in subsection (1)(a)(C). The seasons are open nightly from 7:00 p.m. to 7:00 a.m. the following morning (12 hours), as follows:

(A) Blind Slough and Knappa Slough:
Monday, Wednesday and Thursday nights beginning Monday, February 8 through Friday, March 11 (15 nights);
Monday, March 14 (1 night); and Thursday, March 17 (1 night).

(B) Blind Slough Only: Monday and Thursday nights beginning Monday, March 21 through Tuesday, March 29 (3 nights).

(C) Blind Slough and Knappa Slough from 7:00 p.m. Thursday, July 7, 2016 to 7:00 a.m. the following morning (12 hours); and 7:00 p.m. Tuesday, July 12, 2016 to 7:00 a.m. the following morning (12 hours).

(b) The fishing areas for the winter and spring seasons are:

(A) Blind Slough are those waters from markers at the mouth of Blind Slough upstream to markers at the mouth of Gnat Creek which is located approximately 1/2 mile upstream of the county road bridge.

(B) Knappa Slough are all waters bounded by a line from the northerly most marker at the mouth of Blind Slough westerly to a marker on Karlson Island downstream to a north-south line defined by a marker on the eastern end of Minaker Island to markers on Karlson Island and the Oregon shore.

(C) During the period from May 2 through June 14, the Knappa Slough fishing area extends downstream to the boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon shore.

(c) Gear restrictions are as follows:

(A) During the winter and spring fisheries, outlined above in subsections (1)(a)(A), (1)(a)(B), and (1)(a)(C), gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. The attachment of additional weight and/or anchors directly to the lead line is permitted.

(B) It is unlawful to use a gill net having a mesh size that is less than 7-inches during the winter fishery or greater than 9.75-inches during the spring fishery.

(C) Nets not specifically authorized for use in these areas may be onboard a 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.

(2) Oregon licenses are required in the open waters upstream from the railroad bridge.

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998(Temp), f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 65-2000(Temp) f. 9-22-00, cert. ef. 9-25-00 thru 12-31-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 86-2001, f. & cert. ef. 9-4-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 14-2002(Temp), f. 2-13-02, cert. ef. 2-18-02 thru 8-17-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 16-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 16-2006(Temp), f. 3-23-06 & cert. ef. 3-26-06 thru 7-27-06; DFW 18-2006(Temp), f. 3-29-06, cert. ef. 4-2-06 thru 7-27-06; DFW 20-2006(Temp), f. 4-7-06, cert. ef. 4-9-06 thru 7-27-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06; DFW 75-2006(Temp), f. 8-8-06, cert. ef. 9-5-06 thru 12-31-06; DFW 92-2006(Temp), f. 9-1-06, cert. ef. 9-5-06 thru 12-31-06; DFW 98-2006(Temp), f. & cert. ef. 9-12-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; 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 13-2007(Temp), f. & cert. ef. 3-6-07 thru 9-1-07; DFW 25-2007(Temp), f. 4-17-07, cert. ef. 4-18-07 thru 7-26-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative correction 1-24-08; DFW 6-2008(Temp), f. 1-29-08, cert. ef. 1-31-08 thru 7-28-08; DFW 16-2008(Temp), f. 2-26-08, cert. ef. 3-2-08 thru 8-28-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert . ef. 8-1-08 thru 12-31-08; DFW 103(Temp), f. 8-26-08, cert. ef. 9-2-08 thru 10-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 49-2009(Temp), f. 5-14-09, cert. ef 5-17-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 15-2010(Temp), f. 2-19-10, cert. ef. 2-21-10 thru 6-11-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. & cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 44-2011(Temp), f. & cert. ef. 5-11-11 thru 6-10-11; Administrative correction 6-28-11; DFW 113-2011(Temp), f. 8-10-11, cert. ef. 8-15-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 12-2012(Temp), f. 2-8-12, cert. ef. 2-12-12 thru 7-31-12; DFW 104-2012(Temp), f. 8-6-12, cert. ef. 8-13-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef.

2-11-13 thru 7-31-13; DFW 24-2013(Temp), f. & cert. ef. 3-21-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 91-2013(Temp), f. 8-22-13, cert. ef. 8-26-13 thru 10-31-13; DFW 110-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 115-2014(Temp), f. 8-5-14, cert. ef. 8-18-14 thru 10-31-14; DFW 135-2014(Temp), f & cert. ef. 9-19-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 29-2015(Temp), f. & cert. ef. 4-21-15 thru 7-30-15; DFW 37-2015(Temp), f. 5-1-15, cert. ef. 5-4-15 thru 7-30-15; DFW 70-2015(Temp), f. 6-15-15, cert. ef. 6-16-15 thru 7-31-15; DFW 76-2015(Temp), f. 6-23-15, cert. ef. 6-25-15 thru 7-31-15; DFW 102-2015(Temp), f. 8-10-15, cert. ef. 8-17-15 thru 10-31-15; Administrative correction, 11-20-15; DFW 8-2016(Temp), f. 2-1-16, cert. ef. 2-8-16 thru 7-31-16; DFW 23-2016(Temp), f. & cert. ef. 3-28-16 thru 7-31-16; DFW 32-2016(Temp), f. 4-20-16, cert. ef. 4-21-16 thru 7-31-16; DFW 71-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 78-2016(Temp), f. 6-23-16 thru 7-31-16; DFW 85-2016(Temp), f. & cert. ef. 6-30-16 thru 7-31-16; DFW 87-2016(Temp), f. & cert. ef. 7-7-16 thru 7-31-16

635-042-0170
Tongue Point Basin and South Channel

(1) Tongue Point includes all waters bounded by a line extended from the upstream (southern most) pier (#1) at the Tongue Point Job Corps facility through navigation marker #6 to Mott Island, a line from a marker at the southeast end of Mott Island northeasterly to a marker on the northwest tip of Lois Island, and a line from a marker on the southwest end of Lois Island westerly to a marker on the Oregon shore.

(2) South Channel area includes all waters bounded by a line from a marker on John Day Point to a marker on the southwest end of Lois Island upstream to an upper boundary line from a marker on Settler Point northwesterly to the flashing red USCG marker #10, northwesterly to a marker on the eastern tip of Burnside Island defining the upstream terminus of South Channel.

(3) Salmon and shad may be taken for commercial purposes in those waters of Tongue Point and South Channel as described in section (1) and section (2) of this rule. Retention and sale of white sturgeon is prohibited. The 2016 open fishing periods are:

(a) Winter Season:

Monday and Thursday nights from 7:00 p.m. to 7:00 a.m. the following morning (12 hours) beginning Monday, February 8 through Friday, March 11 (10 nights).

(b) Spring Season:

From 7:00 p.m. Thursday, July 7, 2016 to 7:00 a.m. the following morning (12 hours); and

From 7:00 p.m. Tuesday, July 12, 2016 to 7:00 a.m. the following morning (12 hours).

(4) Gear restrictions are as follows:

(a) In waters described in section (1) as Tongue Point basin, gill nets may not exceed 250 fathoms in length and weight limit on the lead line is not to exceed two pounds on any one fathom. It is unlawful to use a gill net having a mesh size that is less than 7 inches during the winter season or more than 9.75-inches during the spring season.

(b) In waters described in section (2) as South Channel, nets are restricted to 250 fathoms in length with no weight restrictions on the lead line. The attachment of additional weight and/or anchors directly to the lead line is permitted. It is unlawful to use a gill net having a mesh size that is less than 7 inches during the winter season or more than 9.75 inches during the spring season.

(c) Nets not specifically authorized for use in these areas may be onboard a 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.

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; FWC 61-1997(Temp), f. 9-23-97, cert. ef. 9-24-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 41-1998(Temp), f. 5-28-98, cert. ef. 5-29-98; DFW 42-1998(Temp), f. 5-29-98, cert. ef. 5-31-98 thru 6-6-98; DFW 45-1998(Temp), f. 6-5-98, cert. ef. 6-6-98 thru 6-10-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998, f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; Administrative correction 7-30-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 76-2006(Temp), f. 8-8-06, cert. ef. 9-5-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative Correction 1-24-08; DFW 44-2008(Temp), f. 4-25-08, cert. ef. 4-28-08 thru 10-24-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert. ef. 8-1-08 thru 12-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 29-2010(Temp), f. 3-9-10, cert. ef. 4-19-10 thru 6-12-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. & cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 44-2011(Temp), f. & cert. ef. 5-11-11 thru 6-10-11; Administrative correction 6-28-11; DFW 113-2011(Temp), f. 8-10-11, cert. ef. 8-15-11 thru 10-31-11; DFW 122-2011(Temp), f. 8-29-11, cert. ef. 9-19-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 41-2012(Temp), f. 4-24-12, cert. ef. 4-26-12 thru 6-30-12; Administrative correction, 8-1-12; DFW 104-2012(Temp), f. 8-6-12, cert. ef. 8-13-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef. 2-11-13 thru 7-31-13; DFW 34-2013(Temp), f. 5-14-13, cert. ef. 5-15-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 91-2013(Temp), f. 8-22-13, cert. ef. 8-26-13 thru 10-31-13; DFW 110-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 115-2014(Temp), f. 8-5-14, cert. ef. 8-18-14 thru 10-31-14; DFW 135-2014(Temp), f & cert. ef. 9-19-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 29-2015(Temp), f. & cert. ef. 4-21-15 thru 7-30-15; DFW 37-2015(Temp), f. 5-1-15, cert. ef. 5-4-15 thru 7-30-15; DFW 102-2015(Temp), f. 8-10-15, cert. ef. 8-17-15 thru 10-31-15; Administrative correction, 11-20-15; DFW 8-2016(Temp), f. 2-1-16, cert. ef. 2-8-16 thru 7-31-16; DFW 32-2016(Temp), f. 4-20-16, cert. ef. 4-21-16 thru 7-31-16; DFW 71-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 78-2016(Temp), f. 6-23-16 thru 7-31-16; DFW 85-2016(Temp), f. & cert. ef. 6-30-16 thru 7-31-16; DFW 87-2016(Temp), f. & cert. ef. 7-7-16 thru 7-31-16

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Rule Caption: Treaty Indian Commercial Summer Salmon Fishery Modified.
Adm. Order No.: DFW 88-2016(Temp)
Filed with Sec. of State: 7-7-2016
Certified to be Effective: 7-11-16 thru 7-31-16
Notice Publication Date:
Rules Amended: 635-041-0076
Rules Suspended: 635-041-0076(T)
Subject: This amended rule modifies gear restrictions for a previously authorized 3-and-a-half day Treaty Indian commercial salmon gillnet fishery in the Columbia River above Bonneville Dam. The modified fishery begins at 6:00 a.m. Monday, July 11, 2016. Modifications are consistent with action taken July 6, 2016 by the Departments of Fish and Wildlife for the States of Oregon and Washington, in cooperation with the Columbia River Treaty Tribes, at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-041-0076
Summer Salmon Season

(1) Salmon, steelhead, shad, walleye, catfish, bass, yellow perch, and carp may be taken for commercial purposes from Zone 6, in the Columbia River Treaty Indian fishery, from 6:00 a.m. Thursday, June 16 through 11:59 p.m. Sunday, July 31, 2016. Fish caught during any open period may be sold after the period concludes.

(a) White sturgeon between 38–54 inches in fork length caught in the Bonneville Pool and between 43–54 inches in fork length caught in The Dalles Pool and John Day pools may not be sold but may be retained for subsistence use.

(b) Gear is restricted to subsistence fishing gear which includes hoopnets, dipnets, and rod and reel with hook-and-line, with the following exceptions:

(A) Fish may be taken by gill nets with a 7-inch minimum mesh size restriction during the period from 6:00 a.m. Tuesday, July 5 through 6:00 p.m. Friday, July 8 (3.5 days); and

(B) Fish may be taken by gill nets with no mesh size restrictions during the period from 6:00 a.m. Monday, July 11 through 6:00 p.m. Thursday, July 14 (3.5 days).

(c) Closed areas as set forth in OAR 635-041-0045 remain in effect with the exception of Spring Creek Hatchery sanctuary.

(2) Effective 6:00 a.m. Thursday, June 16 through 11:59 p.m. Sunday, July 31, 2016, commercial sales of salmon, steelhead, walleye, shad, catfish, carp, bass and yellow perch caught in Yakama Nation tributary fisheries in the Klickitat River, Wind River, Drano Lake, Icicle Creek and Yakima River are allowed for Yakama Nation members during those days

and hours when these tributaries are open under lawfully enacted Yakama Nation fishing periods.

(a) Sturgeon between 38–54 inches in fork length harvested in tributaries within Bonneville Pool may not be sold but may be kept for subsistence purposes.

(b) Gear is restricted to subsistence fishing gear which includes hoop nets, bag nets, dip nets, and rod and reel with hook-and-line. Gillnets may only be used in Drano Lake.

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; DFW 77-2013(Temp), f. 7-18-13, cert. ef. 7-22-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 66-2014(Temp), f. 6-12-14, cert. ef. 6-16-14 thru 7-31-14; DFW 79-2014(Temp), f. 6-26-14, cert. ef. 6-30-14 thru 7-31-14; DFW 91-2014(Temp), f. 7-10-14, cert. ef. 7-14-14 thru 7-31-14; DFW 95-2014(Temp), f. 7-17-14, cert. ef. 7-21-14 thru 7-31-14; DFW 103-2014(Temp), f.7-23-14, cert. ef. 7-28-14 thru 7-31-14; Administrative correction, 8-28-14; DFW 71-2015(Temp), f. 6-15-15, cert. ef. 6-16-15 thru 7-31-15; DFW 80-2015(Temp), f. 6-30-15, cert. ef. 7-6-15 thru 7-31-15; DFW 83-2015(Temp), f. 7-7-15, cert. ef. 7-8-15 thru 7-31-15; DFW 87-2015(Temp), f. & cert. ef. 7-15-15 thru 7-31-15; DFW 90-2015(Temp), f. 7-20-15, cert. ef. 7-21-15 thru 7-31-15; DFW 93-2015(Temp), f. 7-27-15, cert. ef. 7-28-15 thru 7-31-15; Administrative correction, 8-18-15; DFW 70-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 86-2016(Temp), f. 6-30-16, cert. ef. 7-5-16 thru 8-31-16; DFW 88-2016(Temp), f. 7-7-16, cert. ef. 7-11-16 thru 7-31-16

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Rule Caption: Columbia River Commercial Summer Chinook Drift Net Fishery Set for July 11, 2016.
Adm. Order No.: DFW 89-2016(Temp)
Filed with Sec. of State: 7-7-2016
Certified to be Effective: 7-11-16 thru 7-31-16
Notice Publication Date:
Rules Amended: 635-042-0027
Rules Suspended: 635-042-0027(T)
Subject: This amended rule authorizes an 8-hour non-Indian commercial summer Chinook drift net fishery in the mainstem Columbia River to commence on Monday, July 11 at 9:00 p.m. and run through 5:00 a.m. Tuesday, July 12, 2016 (8 hours) in all of zones 1 through 5. Modifications are consistent with action taken July 6, 2016 by the Oregon and Washington Departments of Fish and Wildlife at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-042-0027
Summer Salmon Season

(1) Chinook and sockeye salmon and shad may be taken by drift net for commercial purposes from the mouth of the Columbia River upstream to Beacon Rock (Zones 1 thru 5) during the period: 9:00 p.m Monday, July 11 to 5:00 a.m. Tuesday, July 12, 2016 (8 hours).

(2) During the summer Chinook fishery:

(a) It is unlawful to use a drift net having a mesh size less than 8 inches;

(b) Mesh size for the fishery is determined as described in OAR 635-042-0010(4); and

(c) 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. Other permanent gear regulations remain in effect.

(3) Sturgeon and steelhead must be released immediately to the river with care and with the least possible injury to the fish.

(4) Closed waters, as described in OAR 635-042-0005 for Elokomin-A, Cowlitz River, Kalama-A, Lewis-A, Sandy and Washougal river sanctuaries are in effect during the open fishing periods identified.

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; Administrative correction, 8-21-13; DFW 67-2014(Temp), f. 6-12-14, cert. ef. 6-16-14 thru 7-31-14; DFW 84-2014(Temp), f. 7-2-14, cert. ef. 7-7-14 thru 7-31-14; DFW 93-2014(Temp), f. 7-10-14, cert. ef. 7-14-14 thru 7-31-14; DFW 102-2014(Temp), f. 7-23-14, cert. ef. 7-28-14 thru 7-31-14; Administrative correction, 8-28-14; DFW 72-2015(Temp), f. 6-15-15, cert. ef. 6-17-15 thru 6-30-15; DFW 84-2015(Temp), f. 7-7-15, cert. ef. 7-8-15 thru 7-31-15; Suspended by DFW 86-2015(Temp), f. & cert. ef. 7-14-15 thru 7-31-15; DFW 91-2015(Temp), f. 7-20-15, cert. ef. 7-21-15 thru 7-31-15; Administrative correction, 8-18-15; DFW 72-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 89-2016(Temp), f. 7-7-16, cert. ef. 7-11-16 thru 7-31-16

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Rule Caption: Electronic Fish Tickets Reporting Commercial Sales Required for Limited Fish Sellers.
Adm. Order No.: DFW 90-2016(Temp)
Filed with Sec. of State: 7-12-2016
Certified to be Effective: 7-29-16 thru 12-31-16
Notice Publication Date:
Rules Amended: 635-006-0210
Rules Suspended: 635-006-0210(T)
Subject: This amended rule requires, by way of electronic fish receiving tickets (e-ticket), the reporting of commercial sales of salmon, sturgeon, smelt and shad landed by "Limited" fish dealers. This rule already requires wholesale fish dealers, wholesale fish bait dealers, and food fish canners to report sales by way of e-tickets. Modifications also require Limited Fish Sellers' e-tickets be submitted within 24 hours of the closure of a fishing period or within 24 hours of the landing when fishing periods are longer than 24 hours.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-006-0210
Fish Receiving Ticket — All Fish

(1) Except as provided in OAR 635-006-0211, for each purchase of food fish or shellfish by a licensed wholesale fish dealer, wholesale fish bait dealer, food fish canner, or shellfish canner from a commercial fisher or commercial bait fisher, the dealer or canner shall prepare at the time of landing a Fish Receiving Ticket, or a separate document in lieu of a Fish Receiving Ticket provided the original dock ticket is attached to the completed dealer copy of the Fish Receiving Ticket and kept on file for inspection by the Director, the Director's authorized agent, or by the Oregon State Police. Fish Receiving Tickets shall be issued in numerical sequence.

(2) Fish Receiving Tickets shall include the following:

(a) Fish dealer's name and license number, including the buying station and location if the food fish or shellfish were received at any location other than the licensed premises of the fish dealer;

(b) Date of landing;

(c) His or her name from whom purchase is made. If not landed from a vessel, then his or her commercial license number shall be added. If received from a Columbia River treaty Indian, his or her tribal affiliation and enrollment number as shown on the official identification card issued

by the U.S. Department of Interior, Bureau of Indian Affairs, or tribal government, shall be used in lieu of an address or commercial fishing license;

(d) Boat name, boat license number, and federal document or State Marine Board number from which catch made;

(e) For groundfish harvested in the limited entry fixed gear fishery, the federal limited entry fixed gear permit number associated with the landing or portion of landing, which shall be provided by the vessel operator to the preparer of the fish ticket;

(f) Port of first landing. The port of first landing will be recorded as where a vessel initially crosses from the Pacific Ocean to inland waters, or is physically removed from the Pacific Ocean, for the purposes of ending a fishing trip;

(g) Fishing gear used by the fisher;

(h) For salmon and Dungeness crab, zone or area of primary catch;

(i) Species or species group, as determined by the Department, of food fish or shellfish received;

(j) Pounds of each species or species group, as determined by the Department, received:

(A) Pounds must be determined and reported based on condition of the fish when landed, either dressed or round. Dressed pounds may only be used for species with a conversion factor listed at OAR 635-006-0215(3)(g). Measures must be taken using a certified scale.

(B) Pounds shall include "weighbacks" by species. "Weighbacks" are those fish or shellfish with no commercial value. The following species or species groups are exempt from fish ticket requirements when considered "weighbacks":

(i) Sponges;
(ii) Sea Pens;
(iii Sea Whips;
(iv) Black Corals;
(v) Sea Fans;
(vi) Anemone;
(vii) Jellyfish;
(viii) Whelks;
(ix) Squids other than Humboldt and market;
(x) Octopus other than Pacific giant octopus;
(xi) Mysids;
(xii) Shrimps other than pink shrimp, coonstripe prawns, and spot prawns;
(xiii) Crabs other than Dungeness, tanner, box, Oregon hair, and red rock crabs;
(xiv) Sea Stars including Brittle Stars;
(xv) Urchins;
(xvi) Sand dollars;
(xvii) Sea cucumbers;
(xviii) Eels other than hagfish;
(xix) Blacksmelts;
(xx) Spookfish;
(xxi) Stomiformes including Viperfish and Blackdragons;
(xxii) Slickheads;
(xxiii) Flatnoses;
(xxiv) Lancetfishes;
(xxv) Barricudinas;
(xxvi) Myctophids;
(xxvii) Tomcod;
(xxviii) Eelpouts including Bigfin, Two line, Black, and Snakehead;
(xxix) Dreamers;
(xxx) Anglerfish;
(xxxi) King of the Salmon;
(xxxii) Melamphids;
(xxxiii) Whalefish;
(xxxiv) Oxeye oreo;
(xxxv) Sculpins other than cabezon, buffalo sculpin, red Irish lord, and brown Irish lord;
(xxxvi) Poachers;
(xxxvii) Snailfish;
(xxxviii) Pricklebacks;
(xxxix) Gunnels;
(xl) Scabbardfish;
(xli) Lancetfish;
(xlii) Ragfish;
(xliii) Slender sole;
(xliv) Deepsea sole;
(xlv) Rays including Pacific and electric Rays and Devilfish;
(xlvi) Wolffishes including wolf eels.

(k) For Columbia River sturgeon the exact number of fish received and the actual round weight of that number of fish;

(l) Price paid per pound for each species received;

(m) Signature of the individual preparing the Fish Receiving Ticket;

(n) Signature of the vessel operator making the landing;

(o) Species name, pounds and value of fish retained by fisher for take home use.

(3) Except as provided in OAR 635-006-0212 and OAR 635-006-0213, the original of each Fish Receiving Ticket covering food fish and shellfish received shall be forwarded within five working days of the date of landing to the Oregon Department of Fish and Wildlife, 4034 Fairview Industrial Drive SE, Salem, OR 97302 or through the Pacific States Marine Fisheries Commission West Coast E-Ticket system or as required by Title 50 of the Code of Federal Regulations, part 660 Subpart C. All fish dealer amendments must be conducted in the same system in which the ticket was initially submitted.

(4) For Columbia River non-treaty mainstem and Select Area commercial fisheries downstream of Bonneville Dam, each licensed wholesale fish dealer, wholesale fish bait dealer, limited fish seller, and food fish canner must submit fish receiving tickets electronically through the Pacific States Marine Fisheries Commission (PSMFC) West Coast E-Ticket System for all salmon, sturgeon, smelt and shad landed. Electronic fish tickets (e-tickets) must be submitted within 24 hours of closure of the fishing period, or within 24 hours of landing for fishing periods lasting longer than 24 hours. All fish dealer amendments to electronic fish tickets must be conducted in the same system in which the tickets were initially submitted.

(5) Wholesale fish bait dealers landing small quantities of food fish or shellfish may request authorization to combine multiple landings on one Fish Receiving Ticket and to deviate from the time in which Fish Receiving Tickets are due to the Department. Such request shall be in writing, and written authorization from the Department shall be received by the wholesale fish bait dealer before any such deviations may occur.

Stat. Auth.: ORS 496.138, 496.146, 496.162, 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.: 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 625-040-0135, Renumbered from 635-036-0580; FWC 1-1986, f. & ef. 1-10-86; 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. 4-13-91; FWC 53-1992, f. 7-17-92, cert. ef. 7-20-92; FWC 16-1995(Temp), f. & cert. ef. 2-16-95; FWC 23-1995, f. 3-29-95, cert. ef. 4-1-95; DFW 63-2003, f. & cert. ef. 7-17-03; DFW 117-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 2-29-04; DFW 10-2004, f. & cert. ef. 2-13-04; DFW 142-2008, f. & cert. ef. 11-21-08; 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 151-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 136-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 100-2015(Temp), f. & cert. ef. 8-4-15 thru 12-31-15; Administrative correction, 1-22-16; DFW 4-2016(Temp), f. 1-26-16, cert. ef. 2-1-16 thru 7-29-16; DFW 90-2016(Temp), f. 7-12-16, cert. ef. 7-29-16 thru 12-31-16

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Rule Caption: In-season Modification to Ocean Recreational Groundfish Depth Restriction.
Adm. Order No.: DFW 91-2016(Temp)
Filed with Sec. of State: 7-12-2016
Certified to be Effective: 7-14-16 thru 12-31-16
Notice Publication Date:
Rules Amended: 635-039-0090
Rules Suspended: 635-039-0090(T)
Subject: This amended rule changes the season closure regulations for rockfish from outside the 30-fathom regulatory curve to outside the 20-fathom curve; and closes the ocean to retention of groundfish outside the 20-fathom curve (as defined by coordinates) from 11:59 p.m. July 14 through December 31, 2016. This action is intended to reduce bycatch mortality of yelloweye rockfish, as the fishery is projected to exceed the allocation within current depth restrictions. These modifications replaced the depth restrictions and closure dates on page 77 of the 2016 Oregon Sport Fishing Regulations shown under the "season" column for: "Rockfish, Greenling, Pacific Cod, Cabezon, Skates, Spiny Dogfish, Leopard Shark, Soupfin Shark, Topsmelt, Jacksmelt, and other marine species not listed here on page 77."
Rules Coordinator: Michelle Tate—(503) 947-6044

635-039-0090
Inclusions and Modifications

(1) The **2016 Oregon Sport Fishing Regulations** provide requirements for sport fisheries for marine fish, shellfish, and marine invertebrates in the Pacific Ocean, coastal bays, and beaches, commonly referred to as

the Marine 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 **2016 Oregon Sport Fishing Regulations**.

(2) For the purposes of this rule, a "sport harvest guideline" is defined as a specified numerical harvest objective that is not a quota. Attainment of a harvest guideline does not automatically close a fishery. Upon attainment of a sport harvest guideline, the Department shall initiate consultation to determine if additional regulatory actions are necessary to achieve management objectives.

(a) The following sport harvest guidelines include the combined landings and other fishery related mortality by the Oregon sport fishery in a single calendar year:

(A) Black rockfish, 440.8 metric tons.

(B) Cabezon, 16.8 metric tons.

(C) Blue rockfish, deacon rockfish, and other nearshore rockfish combined, 26 metric tons.

(b) The following sport harvest guidelines include total landings in the Oregon sport ocean boat fishery in a single calendar year: Greenling, 5.2 metric tons.

(3) For the purposes of this rule, "Other nearshore rockfish" means the following rockfish species: black and yellow (Sebastes chrysolmelas); brown (S. auriculatus); calico (S. dalli); China (S. nebulosus); copper (S. caurinus); gopher (S. carnatus); grass (S. rastrelliger); kelp (S. atrovirens); olive (S. serranoides); quillback (S. maliger); and treefish (S. serriceps).

(4) In addition to the regulations for Marine Fish in the 2016 Oregon Sport Fishing Regulations, the following apply for the sport fishery in the Marine Zone:

(a) Lingcod (including green colored lingcod): 2 fish daily bag limit.

(b) All rockfish ("sea bass" "snapper"), greenling ("sea trout"), cabezon, skates, and other marine fish species not listed in the 2016 Oregon Sport Fishing Regulations in the Marine Zone, located under the category of Species Name, Marine Fish: 7 fish daily bag limit in aggregate (total sum or number), of which no more than three may be blue rockfish or deacon rockfish in aggregate, no more than one may be a canary rockfish, and no more than one may be a cabezon. Retention of the following species is prohibited:

(A) Yelloweye rockfish;

(B) China rockfish;

(C) Copper rockfish;

(D) Quillback rockfish; and

(E) Cabezon from January 1 through June 30.

(c) Flatfish (flounder, sole, sanddabs, turbot, and all halibut species except Pacific halibut): 25 fish daily bag limit in aggregate (total sum or number).

(d) Retention of all marine fish listed under the category of Species Name, Marine Fish, except Pacific cod, sablefish, flatfish, herring, anchovy, smelt, sardine, striped bass, hybrid bass, and offshore pelagic species (excluding leopard shark and soupfin shark), is prohibited when Pacific halibut is retained on the vessel during open days for the all-depth sport fishery for Pacific halibut. Persons must also consult all publications referenced in OAR 635-039-0080 to determine all rules applicable to the taking of Pacific halibut.

(e) Harvest methods and other specifications for marine fish in subsections (4)(a), (4)(b) and (4)(c) including the following:

(A) Minimum length for lingcod, 22 inches.

(B) Minimum length for cabezon, 16 inches.

(C) Minimum length for greenling, 10 inches.

(D) May be taken by angling, hand, bow and arrow, spear, gaff hook, snag hook and herring jigs.

(E) Mutilating the fish so the size or species cannot be determined prior to landing or transporting mutilated fish across state waters is prohibited.

(f) Sport fisheries for species in subsections (4)(a), (4)(b) and (4)(c) and including leopard shark and soupfin shark are open January 1 through December 31, twenty-four hours per day, except as provided in subsections 4(b) and (4)(d). Ocean waters are closed for these species during April 1 through July 14, outside of the 30-fathom curve (defined by latitude and longitude) as shown on Title 50 Code of Federal Regulations Part 660 Section 71, except as provided in subsection 4(d). Ocean waters are closed for these species from July 14 at 11:59 p.m. through December 31, outside of the 20-fathom curve (defined by latitude and longitude) as shown on Title 50 Code of Federal Regulations Part 660 Section 71, except as provided in subsection 4(d). A 20-fathom, 25-fathom, or 30-fathom curve, as shown on Title 50 Code of Federal Regulations Part 660 Section 71 may be implemented as the management line as in-season modifications necessitate. In addition, the following management lines may be used to set area specific regulations for inseason action only:

(A) Cape Lookout (45°20'30" N latitude); and

(B) Cape Blanco (42°50'20" N latitude).

(g) The Stonewall Bank Yelloweye Rockfish Conservation Area (YRCA) is defined by coordinates specified in Title 50 Code of Federal Regulations Part 660 Section 70 (October 1, 2015 ed.). Within the YRCA, it is unlawful to fish for, take, or retain species listed in subsections (4)(a), (4)(b) and (4)(c) of this rule, leopard shark, soupfin shark, and Pacific halibut using recreational fishing gear. A vessel engaged in recreational fishing within the YRCA is prohibited from possessing any species listed in subsections (4)(a), (4)(b) and (4)(c) of this rule, leopard shark, soupfin shark, and Pacific halibut. Recreational fishing vessels in possession of species listed in subsections (4)(a), (4)(b) and (4)(c) and including leopard shark, soupfin shark, and Pacific halibut may transit the YRCA without fishing gear in the water.

(5) Edible Shrimp:

(a) Daily limit is 20 lbs in the shell;

(b) May be taken by traps, pots, or rings.

(6) Razor Clams:

(a) May be taken by hand, shovel, clam gun, or tube with an opening no less than 4 inches in diameter (cylindrical) or 4 inches by 3 inches (elliptical);

(b) All razor clams must be retained regardless of size or condition;

(c) Each digger must have their own container, dig their own clams, and may not possess more than one limit of clams while in the clam digging area except under the allowances of an Oregon Disabilities Hunting and Fishing Permit.

(7) Whale Cove Habitat Refuge: No take of fish, shellfish and marine invertebrates in all areas in Whale Cove below the extreme high tide east of a line drawn across the mouth of the cove, as defined by points at:

(a) 44°47.237'N., 124°04.298'W; and

(b) 44°47.367'N., 124°04.320'W.

NOTE: Table 1, as referenced, is available from the Department.

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 22-1994, f. 4-29-94, cert. ef. 5-2-94; FWC 29-1994(Temp), f. 5-20-94, cert. ef. 5-21-94; FWC 31-1994, f. 5-26-94, cert. ef. 6-20-94; FWC 43-1994(Temp), f. & cert. ef. 7-19-94; FWC 83-1994(Temp), f. 10-28-94, cert. ef. 11-1-94; FWC 95-1994, f. 12-28-94, cert. ef. 1-1-95; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 25-1995, f. 3-29-95, cert. ef. 4-1-95; FWC 26-1995, 3-29-95, cert. ef. 4-2-95; FWC 36-1995, f. 5-3-95, cert. ef. 5-5-95; FWC 43-1995(Temp), f. 5-26-95, cert. ef. 5-28-95; FWC 46-1995(Temp), f. & cert. ef. 6-2-95; FWC 58-1995(Temp), f. 7-3-95, cert. ef. 7-5-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 28-1996(Temp) , f. 5-24-96, cert. ef. 5-26-96; FWC 30-1996(Temp), f. 5-31-96, cert. ef. 6-2-96; 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 68-1999(Temp), f. & cert. ef. 9-17-99 thru 9-30-99; administrative correction 11-17-99; 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 118-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 35-2003, f. 4-30-03, cert. ef. 5-1-03; DFW 114-2003(Temp), f. 11-18-03, cert. ef. 11-21-03 thru 12-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 128-2003, f. 12-15-03, cert. ef. 1-1-04; DFW 83-2004(Temp), f. 8-17-04, cert. ef. 8-18-04 thru 12-31-04; DFW 91-2004(Temp), f. 8-31-04, cert. ef. 9-2-04 thru 12-31-04; DFW 97-2004(Temp), f. 9-22-04, cert. ef. 9-30-04 thru 12-31-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 34-2005(Temp), f. 4-29-05, cert. ef. 5-1-05 thru 10-27-05; DFW 75-2005(Temp), f. 7-13-05, cert. ef. 7-16-05 thru 12-31-05; DFW 87-2005(Temp), f. 8-8-05, cert. ef. 8-11-05 thru 12-31-05; DFW 121-2005(Temp), f. 10-12-05, cert. ef. 10-18-05 thru 12-31-05; DFW 129-2005(Temp), f. & cert. ef. 11-29-05 thru 12-31-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 138-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 141-2005(Temp), f. 12-12-05, cert. ef. 12-30-05 thru 12-31-05; Administrative correction 1-19-06; DFW 61-2006, f. 7-13-06, cert. ef. 10-1-06; DFW 65-2006(Temp), f. 7-21-06, cert. ef. 7-24-06 thru 12-31-06; DFW 105-2006(Temp), f. 9-21-06, cert. ef. 9-22-06 thru 12-31-06; DFW 134-2006(Temp), f. 12-21-06, cert. ef. 1-1-07 thru 6-29-07; DFW 3-2007, f. & cert. ef. 1-12-07; DFW 10-2007, f. & cert. ef. 2-14-07; DFW 66-2007(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 73-2008(Temp), f. 6-30-08, cert. ef. 7-7-08 thru 12-31-08; DFW 97-2008(Temp), f. 8-18-08, cert. ef. 8-21-08 thru 12-31-08; DFW 105-2008(Temp), f. 9-4-08, cert. ef. 9-7-08 thru 12-31-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 7-2009(Temp), f. & cert. ef. 2-2-09 thru 7-31-09; DFW 39-2009, f. & cert. ef. 4-27-09; DFW 110-2009(Temp), f. 9-10-09, cert. ef. 9-13-09 thru 12-31-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 103-2010(Temp), f. 7-21-10, cert. ef. 7-23-10 thru 12-31-10; DFW 157-2010, f. 12-6-10, cert. ef. 1-1-11; DFW 24-2011, f. & cert. ef. 3-22-11; DFW 97-2011(Temp), f. & cert. ef. 7-20-11 thru 12-31-11; DFW 135-2011(Temp), f. 9-21-11, cert. ef. 10-1-11 thru 12-31-11; DFW 155-2011(Temp), f. 11-18-11, cert. ef. 12-1-11 thru 12-31-11; DFW 156-2011(Temp), f. 12-9-11, cert. ef. 12-15-11 thru 1-31-12; DFW 164-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 90-2012(Temp), f. 7-17-12, cert. ef. 9-20-12 thru 12-31-12; DFW 151-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 155-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-29-13; DFW 23-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-27-13; DFW 32-2013, f. & cert. ef. 5-14-13; DFW 112-2013(Temp), f. & cert. ef. 9-27-13 thru 12-31-13; DFW 136-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 165-2014, f. 12-18-14, cert. ef. 1-1-15; DFW 4-2015, f. 1-13-15, cert. ef. 1-15-15; DFW 5-2015(Temp), f. 1-13-15, cert. ef. 1-15-15 thru 7-13-15; Temporary suspended by DFW 18-2015, f. & cert. ef. 3-10-15; DFW 34-2015, f. & cert. ef. 4-28-15; DFW 167-2015, f. 12-29-15, cert. ef. 1-1-16; DFW 3-2016, f. & cert. ef. 1-19-16; DFW 24-2016(Temp), f. 3-30-16, cert. ef. 4-1-16 thru 9-27-16; DFW 35-2016, f. & cert. ef. 4-26-16; DFW 38-2016(Temp), f. & cert. ef. 4-26-16 thru 10-22-16; DFW 91-2016(Temp), f. 7-12-16, cert. ef. 7-14-16 thru 12-31-16

Rule Caption: Commercial Salmon and Shad Fishing Periods Authorized for Columbia River Select Areas.
Adm. Order No.: DFW 92-2016(Temp)
Filed with Sec. of State: 7-13-2016
Certified to be Effective: 7-14-16 thru 7-31-16
Notice Publication Date:
Rules Amended: 635-042-0160, 635-042-0170
Rules Suspended: 635-042-0160(T), 635-042-0170(T)
Subject: This amended rule adds two new 12-hour commercial salmon fishing periods to both the Blind and Knappa sloughs and the Tongue Point/South Channel Select Area fisheries on the Columbia River. Modifications are consistent with action taken July 13, 2016 by the Oregon and Washington Departments of Fish and Wildlife at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-042-0160
Blind Slough and Knappa Slough Select Area Salmon Season

(1) Salmon and shad may be taken for commercial purposes during open 2016 fishing periods described as the winter fishery and the spring fishery in subsections (1)(a)(A) and (1)(a)(B) respectively, of this rule in those waters of Blind Slough and Knappa Slough. Retention and sale of white sturgeon is prohibited. Retention and sales of non-adipose finclipped Chinook salmon from the Blind Slough Select area is prohibited from 12:00 noon through midnite on March 29, 2016. The following restrictions apply:

(a) The open fishing periods are established in segments categorized as the winter fishery in Blind Slough and Knappa Slough in subsection (1)(a)(A), the winter fishery in Blind Slough only in subsection (1)(a)(B), and the spring fishery in Blind Slough and Knappa Slough in subsection (1)(a)(C). The seasons are open nightly from 7:00 p.m. to 7:00 a.m. the following morning (12 hours), as follows:

(A) Blind Slough and Knappa Slough:
Monday, Wednesday and Thursday nights beginning Monday, February 8 through Friday, March 11 (15 nights);

Monday, March 14 (1 night); and Thursday, March 17 (1 night).

(B) Blind Slough Only: Monday and Thursday nights beginning Monday, March 21 through Tuesday, March 29 (3 nights).

(C) Blind Slough and Knappa Slough from 7:00 p.m. Thursday, July 14, 2016 to 7:00 a.m. the following morning (12 hours); and 7:00 p.m. Monday, July 18, 2016 to 7:00 a.m. the following morning (12 hours).

(b) The fishing areas for the winter and spring seasons are:

(A) Blind Slough are those waters from markers at the mouth of Blind Slough upstream to markers at the mouth of Gnat Creek which is located approximately 1/2 mile upstream of the county road bridge.

(B) Knappa Slough are all waters bounded by a line from the northerly most marker at the mouth of Blind Slough westerly to a marker on Karlson Island downstream to a north-south line defined by a marker on the eastern end of Minaker Island to markers on Karlson Island and the Oregon shore.

(C) During the period from May 2 through July 19, 2016, the Knappa Slough fishing area extends downstream to the boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon shore.

(c) Gear restrictions are as follows:

(A) During the winter and spring fisheries, outlined above in subsections (1)(a)(A), (1)(a)(B), and (1)(a)(C), gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. The attachment of additional weight and/or anchors directly to the lead line is permitted.

(B) It is unlawful to use a gill net having a mesh size that is less than 7-inches during the winter fishery or greater than 9.75-inches during the spring fishery.

(C) Nets not specifically authorized for use in these areas may be onboard a 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.

(2) Oregon licenses are required in the open waters upstream from the railroad bridge.

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998(Temp), f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 65-2000(Temp) f. 9-22-00, cert. ef. 9-25-00 thru 12-31-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 86-2001, f. & cert. ef. 9-4-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 14-2002(Temp), f. 2-13-02, cert. ef. 2-18-02 thru 8-17-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 16-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 16-2006(Temp), f. 3-23-06 & cert. ef. 3-26-06 thru 7-27-06; DFW 18-2006(Temp), f. 3-29-06, cert. ef. 4-2-06 thru 7-27-06; DFW 20-2006(Temp), f. 4-7-06, cert. ef. 4-9-06 thru 7-27-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06; DFW 75-2006(Temp), f. 8-8-06, cert. ef. 9-5-06 thru 12-31-06; DFW 92-2006(Temp), f. 9-1-06, cert. ef. 9-5-06 thru 12-31-06; DFW 98-2006(Temp), f. & cert. ef. 9-12-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; 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 13-2007(Temp), f. & cert. ef. 3-6-07 thru 9-1-07; DFW 25-2007(Temp), f. 4-17-07, cert. ef. 4-18-07 thru 7-26-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative correction 1-24-08; DFW 6-2008(Temp), f. 1-29-08, cert. ef. 1-31-08 thru 7-28-08; DFW 16-2008(Temp), f. 2-26-08, cert. ef. 3-2-08 thru 8-28-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert . ef. 8-1-08 thru 12-31-08; DFW 103(Temp), f. 8-26-08, cert. ef. 9-2-08 thru 10-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 49-2009(Temp), f. 5-14-09, cert. ef 5-17-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 15-2010(Temp), f. 2-19-10, cert. ef. 2-21-10 thru 6-11-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. & cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 44-2011(Temp), f. & cert. ef. 5-11-11 thru 6-10-11; Administrative correction 6-28-11; DFW 113-2011(Temp), f. 8-10-11, cert. ef. 8-15-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 12-2012(Temp), f. 2-8-12, cert. ef. 2-12-12 thru 7-31-12; DFW 104-2012(Temp), f. 8-6-12, cert. ef. 8-13-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef. 2-11-13 thru 7-31-13; DFW 24-2013(Temp), f. & cert. ef. 3-21-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 91-2013(Temp), f. 8-22-13, cert. ef. 8-26-13 thru 10-31-13; DFW 110-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 115-2014(Temp), f. 8-5-14, cert. ef. 8-18-14 thru 10-31-14; DFW 135-2014(Temp), f & cert. ef. 9-19-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 29-2015(Temp), f. & cert. ef. 4-21-15 thru 7-30-15; DFW 37-2015(Temp), f. 5-1-15, cert. ef. 5-4-15 thru 7-30-15; DFW 70-2015(Temp), f. 6-15-15, cert. ef. 6-16-15 thru 7-31-15; DFW 76-2015(Temp), f. 6-23-15, cert. ef. 6-25-15 thru 7-31-15; DFW 102-2015(Temp), f. 8-10-15, cert. ef. 8-17-15 thru 10-31-15; Administrative correction, 11-20-15; DFW 8-2016(Temp), f. 2-1-16, cert. ef. 2-8-16 thru 7-31-16; DFW 23-2016(Temp), f. & cert. ef. 3-28-16 thru 7-31-16; DFW 32-2016(Temp), f. 4-20-16, cert. ef. 4-21-16 thru 7-31-16; DFW 71-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 78-2016(Temp), f. 6-23-16 thru 7-31-16; DFW 85-2016(Temp), f. & cert. ef. 6-30-16 thru 7-31-16; DFW 87-2016(Temp), f. & cert. ef. 7-7-16 thru 7-31-16; DFW 92-2016(Temp), f. 7-13-16, cert. ef. 7-14-16 thru 7-31-16

635-042-0170
Tongue Point Basin and South Channel

(1) Tongue Point includes all waters bounded by a line extended from the upstream (southern most) pier (#1) at the Tongue Point Job Corps facility through navigation marker #6 to Mott Island, a line from a marker at the southeast end of Mott Island northeasterly to a marker on the northwest tip of Lois Island, and a line from a marker on the southwest end of Lois Island westerly to a marker on the Oregon shore.

(2) South Channel area includes all waters bounded by a line from a marker on John Day Point to a marker on the southwest end of Lois Island upstream to an upper boundary line from a marker on Settler Point northwesterly to the flashing red USCG marker #10, northwesterly to a marker on the eastern tip of Burnside Island defining the upstream terminus of South Channel.

(3) Salmon and shad may be taken for commercial purposes in those waters of Tongue Point and South Channel as described in section (1) and section (2) of this rule. Retention and sale of white sturgeon is prohibited. The 2016 open fishing periods are:

(a) Winter Season:
Monday and Thursday nights from 7:00 p.m. to 7:00 a.m. the following morning (12

hours) beginning Monday, February 8 through Friday, March 11 (10 nights).

(b) Spring Season:

From 7:00 p.m. Thursday, July 14, 2016 to 7:00 a.m. the following morning (12 hours); and

From 7:00 p.m. Monday, July 118, 2016 to 7:00 a.m. the following morning (12 hours).

(4) Gear restrictions are as follows:

(a) In waters described in section (1) as Tongue Point basin, gill nets may not exceed 250 fathoms in length and weight limit on the lead line is not to exceed two pounds on any one fathom. It is unlawful to use a gill net having a mesh size that is less than 7 inches during the winter season or more than 9.75-inches during the spring season.

(b) In waters described in section (2) as South Channel, nets are restricted to 250 fathoms in length with no weight restrictions on the lead line. The attachment of additional weight and/or anchors directly to the lead line is permitted. It is unlawful to use a gill net having a mesh size that is less than 7 inches during the winter season or more than 9.75 inches during the spring season.

(c) Nets not specifically authorized for use in these areas may be onboard a 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.

Stat. Auth.: ORS 183.325, 506.109 & 506.119

Stats. Implemented: ORS 506.129 & 507.030

Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; FWC 61-1997(Temp), f. 9-23-97, cert. ef. 9-24-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 41-1998(Temp), f. 5-28-98, cert. ef. 5-29-98; DFW 42-1998(Temp), f. 5-29-98, cert. ef. 5-31-98 thru 6-6-98; DFW 45-1998(Temp), f. 6-5-98, cert. ef. 6-6-98 thru 6-10-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998, f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; Administrative correction 7-30-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 76-2006(Temp), f. 8-8-06, cert. ef. 9-5-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative Correction 1-24-08; DFW 44-2008(Temp), f. 4-25-08, cert. ef. 4-28-08 thru 10-24-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert. ef. 8-1-08 thru 12-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 29-2010(Temp), f. 3-9-10, cert. ef. 4-19-10 thru 6-12-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. & cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 44-2011(Temp), f. & cert. ef. 5-11-11 thru 6-10-11; Administrative correction 6-28-11; DFW 113-2011(Temp), f. 8-10-11, cert. ef. 8-15-11 thru 10-31-11; DFW 122-2011(Temp), f. 8-29-11, cert. ef. 9-19-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 41-2012(Temp), f. 4-24-12, cert. ef. 4-26-12 thru 6-30-12; Administrative correction, 8-1-12; DFW 104-2012(Temp), f. 8-6-12, cert. ef. 8-13-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef. 2-11-13 thru 7-31-13; DFW 34-2013(Temp), f. 5-14-13, cert. ef. 5-15-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 91-2013(Temp), f. 8-22-13, cert. ef. 8-26-13 thru 10-31-13; DFW 110-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 115-2014(Temp), f. 8-5-14, cert. ef. 8-18-14 thru 10-31-14; DFW 135-2014(Temp), f & cert. ef. 9-19-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 29-2015(Temp), f. & cert. ef. 4-21-15 thru 7-30-15; DFW 37-2015(Temp), f. 5-1-15, cert. ef. 5-4-15 thru 7-30-15; DFW 102-2015(Temp), f. 8-10-15, cert. ef. 8-17-15 thru 10-31-15; Administrative correction, 11-20-15; DFW 8-2016(Temp), f. 2-1-16, cert. ef. 2-8-16 thru 7-31-16; DFW 32-2016(Temp), f. 4-20-16, cert. ef. 4-21-16 thru 7-31-16; DFW 71-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 78-2016(Temp), f. 6-23-16 thru 7-31-16; DFW 85-2016(Temp), f. & cert. ef. 6-30-16 thru 7-31-16; DFW 87-2016(Temp), f. & cert. ef. 7-7-16 thru 7-31-16; DFW 92-2016(Temp), f. 7-13-16, cert. ef. 7-14-16 thru 7-31-16

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Rule Caption: Treaty Indian Commercial Summer Salmon Fishery Extended.
Adm. Order No.: DFW 93-2016(Temp)
Filed with Sec. of State: 7-14-2016
Certified to be Effective: 7-18-16 thru 7-31-16
Notice Publication Date:
Rules Amended: 635-041-0076
Rules Suspended: 635-041-0076(T)
Subject: This amended rule authorizes two new 4.5 day fishing periods to the ongoing Treaty Indian commercial salmon gill net fishery in the Columbia River above Bonneville Dam. The first new fishing period begins at 6:00 a.m. Monday, July 18 and runs through 6:00 p.m. Friday, July 22, 2016. The second period begins at 6:00 a.m. Monday, July 25 and runs through 6:00 p.m. Friday, July 29, 2016). Modifications are consistent with action taken July 13, 2016 by the Departments of Fish and Wildlife for the States of Oregon and Washington, in cooperation with the Columbia River Treaty Tribes, at a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-041-0076
Summer Salmon Season

(1) Salmon, steelhead, shad, walleye, catfish, bass, yellow perch, and carp may be taken for commercial purposes from Zone 6, in the Columbia River Treaty Indian fishery, from 6:00 a.m. Thursday, June 16 through 11:59 p.m. Sunday, July 31, 2016. Fish caught during any open period may be sold after the period concludes.

(a) White sturgeon between 38–54 inches in fork length caught in the Bonneville Pool and between 43–54 inches in fork length caught in The Dalles Pool and John Day pools may not be sold but may be retained for subsistence use.

(b) Gear is restricted to subsistence fishing gear which includes hoopnets, dipnets, and rod and reel with hook-and-line, with the following exceptions:

(A) Fish may be taken by gill nets with no mesh size restrictions during the following periods: from 6:00 a.m. Monday, July 18 through 6:00 p.m. Friday, July 22 (4.5 days); and

(B) Fish may be taken by gill nets with no mesh size restrictions during the following periods: from 6:00 a.m. Monday, July 25 through 6:00 p.m. Friday, July 29 (4.5 days).

(c) Closed areas as set forth in OAR 635-041-0045 remain in effect with the exception of Spring Creek Hatchery sanctuary.

(2) Effective 6:00 a.m. Thursday, June 16 through 11:59 p.m. Sunday, July 31, 2016, commercial sales of salmon, steelhead, walleye, shad, catfish, carp, bass and yellow perch caught in Yakama Nation tributary fisheries in the Klickitat River, Wind River, Drano Lake, Icicle Creek and Yakima River are allowed for Yakama Nation members during those days and hours when these tributaries are open under lawfully enacted Yakama Nation fishing periods.

(a) Sturgeon between 38–54 inches in fork length harvested in tributaries within Bonneville Pool may not be sold but may be kept for subsistence purposes.

(b) Gear is restricted to subsistence fishing gear which includes hoop nets, bag nets, dip nets, and rod and reel with hook-and-line. Gillnets may only be used in Drano Lake.

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; DFW 77-2013(Temp), f. 7-18-13, cert. ef. 7-22-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 66-2014(Temp), f. 6-12-14, cert. ef. 6-16-14 thru 7-31-14; DFW 79-2014(Temp), f. 6-26-14, cert. ef. 6-30-14 thru 7-31-14; DFW 91-2014(Temp), f. 7-10-14, cert. ef. 7-14-14 thru 7-31-14; DFW 95-2014(Temp), f. 7-17-14, cert. ef. 7-21-14 thru 7-31-14; DFW 103-2014(Temp), f.7-23-14, cert. ef. 7-28-14 thru 7-31-14; Administrative correction, 8-28-14; DFW 71-2015(Temp), f. 6-15-15, cert. ef. 6-16-15 thru 7-31-15; DFW 80-2015(Temp), f. 6-30-15, cert. ef. 7-6-15 thru 7-31-15; DFW 83-2015(Temp), f. 7-7-15, cert. ef. 7-8-15 thru 7-31-15; DFW 87-2015(Temp), f. & cert. ef. 7-15-15 thru 7-31-15; DFW 90-2015(Temp), f. 7-20-15, cert. ef. 7-21-15 thru 7-31-15; DFW 93-2015(Temp), f. 7-27-15, cert. ef. 7-28-15 thru 7-31-15; Administrative correction, 8-18-15; DFW 70-2016(Temp), f. 6-13-16, cert. ef. 6-16-16 thru 7-31-16; DFW 86-2016(Temp), f. 6-30-16, cert. ef. 7-5-16 thru 8-31-16; DFW 88-2016(Temp), f.7-7-16, cert. ef. 7-11-16 thru 7-31-16; DFW 93-2016(Temp), f. 7-14-16, cert. ef. 7-18-16 thru 7-31-16

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Department of Geology and Mineral Industries
Chapter 632

Rule Caption: Amend rule language that addresses ORS 517 revisions
Adm. Order No.: DGMI 2-2016
Filed with Sec. of State: 6-27-2016
Certified to be Effective: 6-27-16
Notice Publication Date: 4-1-2016
Rules Amended: 632-030-0016, 632-030-0022
Rules Repealed: 632-030-0016(T), 632-030-0022(T)
Subject: Establishes requirements for an Exclusion Certificate, including an $80 application fee, for a person that engages in surface mining activities at levels below thresholds for applicability of operating permit and reclamation requirements. An Exclusion Certificate application for an aggregate mining operation must be received no later than September 30, 2016, or within 90 days after excavation commences, whichever is later. An Exclusion Certificate application for a nonaggregate mineral mining operation must be received no later than July 31, 2017, or within 90 days after excavation commences, whichever is later. All EC annual renewal fees are set at $150 by statute (ORS 517.753).
Rules Coordinator: Robert Houston—(541) 619-4653

632-030-0016
Exclusion Certificates

(1) Pursuant to ORS 517.753, an exclusion certificate is required for a surface mining operation that falls under the yard and acre thresholds for which an operating permit is required. A person seeking an exclusion certificate must file an application as provided in section (2) of this rule and the application must be accompanied by the nonrefundable fee required under OAR 632-030-0022. The application must be filed in accordance with the schedule established in section (3) of this rule.

(a) When a mining operation that is subject to an exclusion certificate loses its eligibility and is required to obtain an operating permit, all areas and operations at the site are subject to the Act and the rules adopted thereunder. When multiple mining areas are located within one parcel or contiguous parcels, the yards produced and disturbed acreage will be calculated based on the total of all sites within the parcel or contiguous parcels.

(b) Excavation or other land disturbance operations reasonably necessary for farming include only the term "farming" as used in ORS 517.750(15)(b)(B) and means "farm use" as defined in ORS 215.203 but does not include other uses permitted in exclusive farm-use zones under ORS 215.213 or 215.283. Farm excavation or other land disturbance operations are reasonably necessary only if it substantially contributes to the profitability of the farm use and other alternatives to accomplish the same objective are significantly more expensive or otherwise impractical. Farming does not include excavation for ponds intended for recreational or aesthetics purposes or for fish or wildlife habitat.

(2) An application for an exclusion certificate must be made on the form approved by the Department. The application must include the following information:

(a) The name of the operator;

(b) Location of the excavation;

(c) The ownership of the property; if the operator is not the landowner, the operator will provide written proof of land owner's permission to mine the site on the landowner's property;

(d) Size of the site;

(e) Date of commencement of the excavation;

(f) A summary of the previous 36 months' activities and an estimate of the activity for the succeeding 36 months;

(g) An explanation of why the activity is exempt; and

(h) Any other information that the Department determines to be useful to determine whether an operation is properly excluded from permitting and reclamation requirements.

(3) Applications for nonaggregate mineral surface mining operations (including placer mines) must be filed no later than July 31, 2017, or within 90 days after excavation commences, whichever is later.

(4) Applications for sand, gravel, aggregate, or crushed stone mining operations must be received no later than September 30, 2016, or within 90 days after excavation commences, whichever is later.

(5) The Department will review an application upon receipt and notify the applicant whether the application is complete. If an application is deemed incomplete it will be returned to the applicant with a description of the missing information.

(6) The holder of an exclusion certificate must file an annual report on the anniversary date of the issuance of the certificate. The annual report must be accompanied by the annual fee established in ORS 517.753 and must include the following information:

(a) Volume of minerals extracted, or mineral deposits and overburden disturbed during the previous year;

(b) Amount of additional lands affected by mining during the previous year; and

(c) Total number of acres affected by the operation.

Stat. Auth.: ORS 517
Stats. Implemented: ORS 517.750
Hist.: GMI 5, f. 12-20-73, ef. 1-11-74; GMI 7, f. 11-7-74, ef. 12-11-74; GMI 1-1980, f. 2-29-80, ef. 3-1-80; GMI 2-1982, f. & ef. 8-13-82; GMI 2-1985, f. 11-19-85, ef. 11-20-85; GMI 2-1986, f. 9-19-86, ef. 9-22-86; GMI 1-1988, f. 3-30-88, cert. ef. 3-11-88; GMI 2-1997, f. & cert. ef. 10-14-97; DGMI 1-1999, f. & cert. ef. 1-7-99; DGMI 1-2000, f. & cert. ef. 7-20-00; DGMI 1-2009, f. & cert. ef. 5-15-09; DGMI 1-2016(Temp), f. & cert. ef. 1-14-16 thru 6-30-16; DGMI 2-2016, f. & cert. ef. 6-27-16

632-030-0022
Fees

(1) The fees applicable to this rule division are pursuant to ORS 517.753 and 517.800. The application fee for an exclusion certificate is $80. Each holder of an exclusion certificate will annually pay to the department a renewal fee of $150 pursuant to ORS 517.753.

(2) Annual fees are due on the anniversary date of the issuance of the operating permit, limited exemption certificate, or exclusion certificate unless a different renewal date is established by the Department. The Department will provide the permittee or certificate holder with 60 days advance notice before establishing a new renewal date. The Department will prorate annual fees at the permittee's or certificate holder's request if a new renewal date is established.

(3) A permittee or certificate holder must renew their permit or certificate annually, on or before the last day of the month shown on the permit or certificate as the renewal month. Operators that hold both a limited exemption certificate and an operating permit on the same property, or contiguous properties that are operated as a single mining activity, will pay a single annual renewal fee pursuant to ORS 517.800, based upon the total reported production from all sites within the parcel or contiguous parcels. The non refundable annual fee must be paid and the annual report form returned prior to renewal. A permittee or certificate holder must pay all delinquent fees and accrued interest owed to this Department prior to renewal, transfer, or amendment of the permit or certificate.

(4) The Department will impose a late fee equal to five percent of the amount of any annual fee that is more than 60 days past due.

(5) The fees established by this rule also apply to emergency permits issued pursuant to ORS 517. 832 and temporary operating permits issued under ORS 517.834.

(6) The Department may waive the fee for a minor amendment in those situations where significant administrative resources are not needed to process the amendment.

Stat. Auth.: ORS 517
Stats. Implemented: ORS 517.800
Hist.: GMI 2-1997, f. & cert. ef. 10-14-97; DGMI 1-1999, f. & cert. ef. 1-7-99; DGMI 1-2000, f. & cert. ef. 7-20-00; DGMI 2-2003, f. & cert. ef. 8-22-03; DGMI 3-2003, f. 8-29-03, cert. ef. 9-1-03; DGMI 1-2005(Temp), f. & cert. ef. 8-3-05 thru 1-30-06; DGMI 1-2006, f. & cert. ef. 1-10-06; DGMI 1-2009, f. & cert. ef. 5-15-09; DGMI 1-2016(Temp), f. & cert. ef. 1-14-16 thru 6-30-16; DGMI 2-2016, f. & cert. ef. 6-27-16

Department of Human Services,
Administrative Services Division and Director's Office
Chapter 407

Rule Caption: Implement SB 1515 Background Check Changes and Correct CMS Requirements in Provider Rules
Adm. Order No.: DHSD 6-2016(Temp)
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 407-007-0210, 407-007-0250, 407-007-0279, 407-007-0290, 407-007-0320
Subject: Oregon Laws 2016, chapter 106, section 6 (2016 SB1515) becomes effective 7/1/2016. It added requirements regarding proctor foster parent applying for certification or recertification through a child-caring agency. These requirements have been added to the rules, and include:

The addition of disclosure language needed in the background check request to allow the Department to release information to the child-caring agency.

The requirement that the proctor foster parent disclose all substantiated or founded abuse, and all protective orders or restraining orders against the proctor foster parent.

The addition of serious adult neglect, protective orders or restraining orders against the proctor foster parent, and financial abuse about these as potentially disqualifying.

The addition of false statement about abuse or protective orders/restraining orders by the proctor foster parent as a reason to close background check request.

OAR 407-007-0279 is being updated to follow CMS guidelines that the mandatory exclusion from holding a position due to certain convictions or conditions is only for 5 years; the previous rule language had an error that needed correcting immediately to match current requirements.

Proposed rules are available on the Department of Human Services website: http://www.oregon.gov/DHS/POLICIES/Pages/ss-admin-rules.aspx. For hardcopy requests, call: (503) 947-5250.
Rules Coordinator: Jennifer Bittel—(503) 947-5250

407-007-0210
Definitions

In addition to the definitions in OAR 125-007-0210 and 407-007-0010, the following definitions apply to OAR 407-007-0200 to 407-007-0370:

(1) "Appointing authority" means an individual designated by the qualified entity (QE) who is responsible for appointing QE designees (QEDs). Examples include but are not limited to human resources staff with the authority to offer and terminate employment, a business owner, a member of the board of directors, a director, or a program administrator.

(2) "Child-caring agency proctor foster parent" means an individual who is an applicant for certification or recertification of a proctor foster home by a child-caring agency pursuant to OAR 413-215-0301 to 413-215-0396.

(3) "Ineligible due to ORS 443.004" means BCU has determined that an SI, subject to ORS 443.004 and either OAR 407-007-0275 or 407-007-0277, has one or more convictions that prohibit the SI from holding the position listed in the background check request.

(4) "Mandatory exclusion" means BCU has determined that an SI, subject to federal law or regulation, has one or more convictions or conditions that prohibit the SI from holding the position listed in the background check request.

(5) "Qualified entity (QE)" means a community mental health or developmental disability program, local health department, or an individual, business, or organization, whether public, private, for-profit, nonprofit, or voluntary, that provides care, including a business or organization that licenses, certifies, or registers others to provide care (see ORS 181A.200).

(6) "QE designee (QED)" means an individual appointed by the QE's appointing authority to handle background checks on behalf of the QE.

(7) "QE Initiator (QEI)" means an approved SI who BCU has granted access to the Criminal Information Management System (CRIMS) for one QE for the purpose of entering background check request data.

(8) "Subject individual (SI)" means an individual on whom BCU conducts a criminal records check and an abuse check, and from whom BCU may require fingerprints for the purpose of conducting a national criminal records check.

(a) An SI includes any of the following:

(A) An individual who is licensed, certified, registered, or otherwise regulated or authorized for payment by the Department or Authority and who provides care.

(B) An employee, contractor, temporary worker, or volunteer who provides care or has access to clients, client information, or client funds within or on behalf of any entity or agency licensed, certified, registered, or otherwise regulated by the Department or Authority.

(C) Any individual who is paid directly or indirectly with public funds who has or will have contact with recipients of:

(i) Services within an adult foster home (defined in ORS 443.705); or

(ii) Services within a residential facility (defined in ORS 443.400).

(D) Any individual who works in a facility and provides care or has access to clients, client information, or client funds secured by any residential care or assisted living facility through the services of a personnel services or staffing agency.

(E) Any individual who works in a facility and provides care, or has access to clients, client information, or client funds secured by any nursing facility through the services of a personnel services or staffing agency.

(F) Except as excluded in section (8)(b)(C) and (D) of this rule, an individual who lives in a facility that is licensed, certified, registered, or otherwise regulated by the Department to provide care. The position of this SI includes but is not limited to resident manager, household member, or boarder.

(G) For any child foster home, proctor foster home or child adoptive home certified by a child-caring agency governed by OAR chapter 413 division 215:

(i) A child-caring agency proctor foster parent;

(ii) An adoptive parent applicant or an approved adoptive parent;

(ii) An employee, contractor, or volunteer;

(iii) An adult household member in an adoptive or child foster home 18 years of age and over; and

(iv) A household member in an adoptive or child foster home under 18 years of age if there is reason to believe that the household member may pose a risk to children placed in the home.

(H) An individual with contact with clients, client information, or client funds, who is working, contracted with, or volunteering for a child-caring agency or residential program for children governed by OAR chapter 413 division 215; an In-Home Safety and Reunification Services (ISRS) program, a Strengthening, Preserving and Reunifying Families (SPRF) provider, or system of care contractor providing child welfare services pursuant to ORS Chapter 418.

(I) A homecare worker as defined in ORS 410.600, a personal support worker as defined in ORS 410.600, a personal care services provider, or an independent provider employed by a Department or Authority client who provides care to the client if the Department or Authority helps pay for the services.

(J) A child care provider and their employees reimbursed through the Department's child care program and other individuals in child care facilities that are exempt from certification or registration by the Office of Child Care of the Oregon Department of Education. This includes all individuals listed in OAR 461-165-0180.

(K) An appointing authority, QED, or QEI associated with any entity or agency licensed, certified, registered, otherwise regulated by the Department, or subject to these rules.

(L) An individual providing on the job certified nursing assistant classes to staff within a long term care facility.

(M) A student enrolled in a Board of Nursing approved nursing assistant training program in which the instruction and training occurs solely in a nursing facility.

(N) Except for those excluded under section (8)(b)(B), a student or intern who provides care or has access to clients, client information, or client funds within or on behalf of a QE.

(O) Any individual serving as an owner, operator, or manager of a room and board facility pursuant to OAR chapter 411, division 68.

(P) An employee providing care to clients of the Department's Aging and People with Disabilities (APD) programs who works for an in-home care agency as defined by ORS 443.305 which has a contract with the Department's APD programs.

(Q) Any individual who is required to complete a background check pursuant to Department or Authority program rules or a contract with the

Department or Authority, if the requirement is within the Department or Authority's statutory authority. Specific statutory authority or reference to these rules and the positions under the contract subject to a background check must be specified in the contract. The exceptions in section (8)(b) do not apply to these SIs.

(b) An SI does not include:

(A) Any individual under 16 years of age.

(B) A student or intern in a clinical placement at a clinical training setting subject to administrative rules implemented under ORS 413.435.

(C) Department, Authority, or QE clients. The only circumstance in which BCU shall allow a check to be performed on a client pursuant to this paragraph is if the client falls within the definition of "subject individual" as listed in sections (8)(a)(A)–(F) and (8)(a)(G)–(Q) of this rule, or if the facility is dually licensed for different populations of vulnerable individuals.

(D) Individuals working in child care facilities certified or registered by OED.

(E) Individuals employed by a private business that provides services to clients and the general public and is not regulated by the Department or Authority.

(F) Individuals employed by a business that provides appliance or structural repair for clients and the general public and who are temporarily providing these services in a licensed or certified QE. The QE shall ensure active supervision of these individuals while on QE property and the QE may not allow unsupervised contact with QE clients or residents. This exclusion does not apply to a business that receives funds from the Department or Authority for care provided by an employee of the business.

(G) Individuals employed by a private business in which a client of the Department or Authority is working as part of a Department- or Authority-sponsored employment service program. This exclusion does not apply to an employee of a business that receives funds from the Department or Authority for care provided by the employee.

(H) Employees, contractors, students, interns, and volunteers working in hospitals, ambulatory surgical centers, outpatient renal dialysis facilities, and freestanding birthing centers, as defined in ORS 442.015, and special inpatient care facilities as defined by the Authority in administrative rule.

(I) Volunteers, who are not under the direction and control of a licensed, certified, registered, or otherwise regulated QE.

(J) Individuals employed or volunteering in a Medicare-certified health care business which is not subject to licensure or certification by the State of Oregon.

(K) Individuals working in restaurants or at public swimming pools.

(L) Hemodialysis technicians.

(M) Employees, contractors, temporary workers, or volunteers who provide care, or have access to clients, client information, or client funds of an alcohol and drug program that is certified, licensed, or approved by the Authority's Health Systems Division to provide prevention, evaluation, or treatment services. This exclusion does not apply to programs specifically required by other Authority program rules to conduct criminal records checks in accordance with these rules.

(N) Individuals working for a transit service provider which conducts background checks pursuant to ORS 267.237.

(O) Emergency medical technicians and first responders certified by the Authority's Emergency Medical Services and Trauma Systems program.

(P) Employees, contractors, temporary workers, or volunteers of continuing care retirement communities registered under OAR chapter 411, division 67.

(Q) Individuals hired by or on behalf of a resident in a QE to provide care privately to the resident.

(R) An employee, contractor, temporary worker, or volunteer who provides care or has access to clients, client information, or client funds within or on behalf of any entity or agency licensed, certified, registered, or otherwise regulated by the Department or Authority, where the clients served permanently reside in another state.

Stat. Auth.: ORS 181A.200, 409.027 & 409.050

Stats. Implemented: ORS 181A.195, 181A.200, 409.010, 409.027, 443.004, & OL 2016, chapter 106, section 6

Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04; OMAP 77-2004(Temp), f. & cert. ef. 10-1-04 thru 3-29-05; OMAP 22-2005, f. & cert. ef. 3-29-05; Renumbered from 410-007-0210, DHSD 8-2007, f. 8-31-07, cert. ef. 9-1-07; Hist.: DHSD 2-2008(Temp), f. & cert. ef. 3-31-08 thru 9-26-08; DHSD 7-2008, f. 8-29-08, cert. ef. 9-1-08; DHSD 10-2008, f. 12-26-08, cert. ef. 1-1-09; DHSD 2-2009, f. & cert. ef. 4-1-09; DHSD 7-2009, f. & cert. ef. 10-1-09; DHSD 10-2009, f. 12-31-09, cert. ef. 1-1-10; DHSD 8-2010(Temp), f. & cert. ef. 8-12-10 thru 2-7-11; DHSD 10-2010, f. 10-29-10, cert. ef. 10-31-10; DHSD 1-2011(Temp) f. & cert. ef. 4-15-11 thru 10-11-11; DHSD 7-2011(Temp), f. & cert. ef. 10-12-11 thru 11-1-11; DHSD 8-2011, f. 10-28-11, cert. ef. 11-1-11; DHSD 2-2012(Temp), f. & cert. ef. 2-27-12 thru 8-24-12; DHSD 4-2012, f. & cert. ef. 8-1-12; DHSD 1-2013(Temp), f. & cert. ef. 2-5-13 thru 8-2-13; DHSD 3-2013, f. & cert. ef. 8-1-13; DHSD 2-2014, f. & cert. ef. 12-1-14; DHSD 1-2016(Temp), f. & cert. ef. 1-14-16 thru 7-11-16; DHSD 5-2016, f. 6-10-16, cert. ef. 6-15-16; DHSD 6-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-007-0250
Background Check Process

(1) A QE and SI shall use CRIMS to request a background check. In addition to information required in OAR 125-007-0220, the background check request shall include the following information regarding an SI:

(a) Worksite location or locations where the SI will be working;

(b) Disclosure of all criminal history;

(A) The SI must disclose all arrests, charges, and convictions regardless of outcome or when the arrests, charges, or convictions occurred. Disclosure includes any juvenile record of arrests, charges, or the outcome of arrests or charges against a juvenile.

(B) The disclosed crimes and the dates must reasonably match the SI's criminal offender information and other criminal records information, as determined by BCU.

(c) Disclosure of other information to be considered in the event of a weighing test.

(A) The SI may provide mitigating information for BCU to review in a weighing test.

(B) BCU may require the SI to provide other information as needed to conduct the weighing test.

(d) For an SI who is child-caring agency proctor foster parent:

(A) The SI must provide a release of information allowing the Department to provide the QE with information regarding the open or pending abuse investigations or substantiated allegations of abuse or neglect against the SI.

(B) The SI must also disclose:

(i) Any currently open or pending child or adult protective services abuse or neglect investigations;

(ii) Any substantiations of child or adult abuse or neglect investigations; and

(iii) Any restraining order or protective order against the SI.

(C) If the SI has any of the following, the Department shall provide the QE notification:

(i) Information regarding the open or pending abuse investigations in which the SI is a reported or alleged perpetrator.

(ii) Information regarding substantiated allegations of abuse or neglect against the SI.

(iii) Confirmation of the SI being certified or licensed by the Department Child Welfare programs as a child foster home provider.

(2) The background check request shall include the following notices to the SI:

(a) A notice regarding disclosure of Social Security number indicating that:

(A) The SI's disclosure is voluntary; and

(B) The Department requests the Social Security number solely for the purpose of positively identifying the SI during the criminal records check process.

(b) A notice that the SI may be subject to fingerprinting as part of a criminal records check.

(c) A notice that BCU shall conduct an abuse check on the SI. Unless required by program rule, an SI is not required to disclose any history of potentially disqualifying abuse, but may provide BCU with mitigating or other information.

(3) Using identifying information submitted in a background check request, BCU shall conduct an abuse check to determine if the subject individual has potentially disqualifying abuse.

(4) BCU shall conduct an Oregon criminal records check. Using information submitted on the background check request, BCU may obtain criminal offender information from LEDS and may request other criminal records information as needed.

(5) BCU shall handle criminal offender information in accordance with applicable OSP requirements in ORS chapter 181 and the rules adopted pursuant thereto (see OAR chapter 125, division 007 and chapter 257, division 15).

(6) BCU may conduct a fingerprint-based national criminal records check.

(a) A fingerprint-based national criminal records check may be completed under any of the following circumstances:

(A) The SI has been outside Oregon:

(i) For 60 or more consecutive days during the previous 18 months and the SI is a child care provider or other individual included in OAR 461-165-0180.

(ii) For 60 or more consecutive days during the previous five years for all other SIs.

(B) The LEDS check, SI disclosures, or any other criminal records information obtained by BCU indicate there may be criminal records outside of Oregon.

(C) The SI has an out-of-state driver license or out-of-state identification card.

(D) BCU or the QE has reason to question the identity of the SI or the information on the criminal record found in LEDS.

(E) A fingerprint-based criminal records check is required by federal or state laws or regulations, other Department or Authority rules, or by contract with the Department or Authority.

(F) The SI is an employee of an agency which the Centers for Medicare and Medicaid Services has designated high risk pursuant to 42 CFR 424.518.

(G) Any SI applying to be or renewing the position with regard to child adoption or children in foster care licensed by the Department or child-caring agencies. Renewing SIs do not need a fingerprint-based criminal records check if BCU has a record of a previous fingerprint-based criminal records checks that is within BCU's retention schedule. Applicable SI positions include:

(i) A relative caregiver, foster parent, or adoptive parent in Oregon;

(ii) An adult household member in an adoptive or child foster home 18 years of age and over;

(iii) A household member in an adoptive or child foster home under 18 years of age if there is reason to believe that the household member may pose a risk to children placed in the home; or

(iv) A respite care provider in an adoptive or child foster home.

(H) BCU has reason to believe that fingerprints are needed to make a final fitness determination.

(b) BCU shall request a fingerprint capture for an SI under the age of 18 in accordance with OAR 125-007-0220(3).

(c) The SI shall complete and submit a fingerprint capture when requested by BCU within the time frame indicated in a written notice. BCU shall send the request to the QE and the QED shall notify the SI.

(A) BCU shall give the SI notice regarding the Social Security number as set forth in section (2)(a) of this rule.

(B) BCU may require new fingerprint capture and its submission if previous fingerprint captures results in a rejection by OSP or the FBI.

(7) BCU may also conduct a state-specific criminal records check instead of or in addition to a national criminal records check. Reasons for a state-specific criminal records check include but are not limited to:

(a) When BCU has reason to believe that out-of-state criminal records may exist and a national criminal records check cannot be accomplished.

(b) When BCU has been unable to complete a national criminal records check due to illegible fingerprints.

(c) When the national criminal records check results show incomplete information about charges or criminal records without final disposition.

(d) When there is indication of residency or criminal records in a state that does not submit all criminal records to the FBI.

(e) When, based on available information, BCU has reason to believe that a state-specific criminal records check is necessary.

(8) In order to complete a background check and fitness determination, BCU may require additional information from the SI including but not limited to additional criminal, judicial, other background information, or proof of identity.

(9) BCU may conduct a background check in situations of imminent danger.

(a) If the Department or Authority determines there is indication of criminal or abusive behavior that could more likely than not pose an immediate risk to vulnerable individuals, BCU shall conduct a new criminal records check on an SI without the completion of a new background check request.

(b) If BCU determines that a fitness determination based on the new background check would be adverse to the SI, BCU shall provide the SI, if available, the opportunity to disclose criminal records, potentially disqualifying conditions, and other information as indicated in OAR 407-007-0300 before completion of the fitness determination.

(10) All criminal records checks conducted under this rule shall be documented.

Stat. Auth.: ORS 181A.200, 409.027 & 409.050

Stats. Implemented: ORS 181A.195, 181A.200, 409.010, & OL 2016, chapter 106, section 6

Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04; OMAP 22-2005, f. & cert. ef. 3-29-05; Renumbered from 410-007-0250, DHSD 8-2007, f. 8-31-07, cert. ef. 9-1-07; DHSD 10-2008, f. 12-26-08, cert. ef. 1-1-09; DHSD 2-2009, f. & cert. ef. 4-1-09; DHSD 7-2009, f. & cert. ef. 10-1-09; DHSD 10-2009, f. 12-31-09, cert. ef. 1-1-10; DHSD 10-2010, f. 10-29-10, cert. ef. 10-31-10; DHSD 1-2011(Temp) f. & cert. ef. 4-15-11 thru 10-11-11; DHSD 7-2011(Temp), f. & cert. ef. 10-12-11 thru 11-1-11; DHSD 8-2011, f. 10-28-11, cert. ef. 11-1-11; DHSD 2-2012(Temp), f. & cert. ef. 2-27-12 thru 8-24-12; DHSD 4-2012, f. & cert. ef. 8-1-12; DHSD 3-2013, f. & cert. ef. 8-1-13; DHSD 2-2014, f. & cert. ef. 12-1-14; DHSD 1-2016(Temp), f. & cert. ef. 1-14-16 thru 7-11-16; DHSD 5-2016, f. 6-10-16, cert. ef. 6-15-16; DHSD 6-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-007-0279

Federal Mandatory Exclusions

(1) Convictions and conditions under 42 USC 1320a-7(a) result in mandatory exclusion for SIs if they occurred within five years from the date the background check request was electronically submitted to BCU through CRIMS or the date BCU conducted a criminal records check due to imminent danger. If the convictions and conditions under 42 USC 1320a-7(a) occurred after five years, the individual is subject to a fitness determination under OAR 125-007-0260 and 407-007-0320.

(a) Section (1) of this rule applies to an SI who is:

(A) Home care worker or personal support worker as defined in ORS 410.600.

(B) Is employed by:

(i) A residential facility as defined in ORS 443.400 that receives Medicare or state health care funds;

(ii) An in-home care agency as defined in ORS 443.005 that receives Medicare or state health care funds;

(iii) A home health agency as defined in ORS 443.005 that receives Medicare or state health care funds;

(b) If BCU determines that an individual is subject to this rule and has an exclusion listed in 42 USC 1320a-7, BCU shall make the determination of mandatory exclusion. Convictions or conditions requiring mandatory exclusion include:

(A) Convictions related to the delivery of Medicare or State health care program services.

(B) Convictions related to the abuse of a client or patient.

(C) Felony convictions related to health care fraud.

(D) Felony convictions related to the manufacture, delivery, prescription or dispensing of a controlled substance.

(c) Under OAR 125-007-0260, the determination of mandatory exclusion is considered an incomplete fitness determination. A fitness determination with a weighing test is not required regardless of any other potentially disqualifying convictions and conditions the SI has.

(d) A determination of mandatory exclusion is subject to appeal rights only if allowed under 42 UCS 1320a-7(c) or 42 USC 1320a-7(d). If allowed, appeals shall comply with OAR 125-007-0300, 943-007-0335 and 943-007-0501.

(2) Convictions and conditions under 42 USC 12645g result in mandatory exclusion for SIs.

(a) Section (2) of this rule applies to a SIs who working or volunteering under the National and Community Service Act of 1990 as amended by the Serve America Act, including participants and employees in:

(A) Americorps;

(B) Foster Grandparents;

(C) Senior Companions; or

(D) Any other programs funded under national service laws.

(b) If BCU determines that an individual is subject to this rule and has an exclusion listed in 42 USC 12645g, BCU shall make the determination of mandatory exclusion. Exclusions include:

(A) Listing on, or requirement to be listed on a sex offender registry;

(B) Conviction for murder.

(C) Refusal to complete the background check.

(D) False statement by the SI in connection with criminal history disclosure.

(c) Under OAR 125-007-0260(2)(d), the determination of "mandatory exclusion" is considered an incomplete fitness determination. A fitness determination with a weighing test is not required regardless of any other potentially disqualifying convictions and conditions the SI has.

(d) A determination of "mandatory exclusion" due to 42 USC 12645g is not subject to appeal rights under OAR 125-007-0300, 407-007-0330, 407-007-0335, 943-007-0335, or 943-007-0501.

Stat. Auth.: ORS 181A.195 & 409.050

Stats. Implemented: ORS 181A.195

Hist.; DHSD 5-2016, f. 6-10-16, cert. ef. 6-15-16; DHSD 6-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-007-0290

Other Potentially Disqualifying Conditions

Pursuant to OAR 125-007-0270, the following are potentially disqualifying conditions, if they exist on the date the Department receives the background check request:

(1) The SI makes a false statement to the QE or Department, including the provision of materially false information, false information regarding criminal records, or failure to disclose information regarding criminal records. Nondisclosure of violation or infraction charges may not be considered a false statement.

(2) The SI is a registered sex offender in any jurisdiction. There is a rebuttable presumption that an SI is likely to engage in conduct that would pose a significant risk to vulnerable individuals if the SI has been designated a predatory sex offender in any jurisdiction under ORS 181.585 or found to be a sexually violent dangerous offender under ORS 144.635 (or similar statutes in other jurisdictions).

(3) The SI has an outstanding warrant for any crime in any jurisdiction.

(4) The SI has a deferred sentence, conditional discharge, or is participating in a diversion program for any crime in any jurisdiction.

(5) The SI is currently on probation, parole, or post-prison supervision for any crime in any jurisdiction, regardless of the original conviction date (or date of guilty or no contest plea if there is no conviction date).

(6) The SI has been found in violation of post-prison supervision, parole, or probation for any crime in any jurisdiction, regardless of the original conviction date (or date of guilty or no contest plea if there is no conviction date) within five years from the date the background check request was electronically submitted to BCU through CRIMS or the date BCU conducted a criminal records check due to imminent danger.

(7) The SI has an unresolved arrest, charge, or a pending indictment for any crime in any jurisdiction.

(8) The SI has been arrested in any jurisdiction as a fugitive from another state or a fugitive from justice, regardless of the date of arrest.

(9) The SI has an adjudication in a juvenile court in any jurisdiction, finding that the SI was responsible for a potentially disqualifying crime that would result in a conviction if committed by an adult. Subsequent adverse rulings from a juvenile court, such as probation violations, shall also be considered potentially disqualifying if within five years from the date the background check request was signed or the date BCU conducted a criminal records check due to imminent danger.

(10) The SI has a finding of "guilty except for insanity," "guilty except by reason of insanity," "not guilty by reason of insanity," "responsible except for insanity," "not responsible by reason of mental disease or defect," or similarly worded disposition in any jurisdiction regarding a potentially disqualifying crime, unless the local statutes indicate that such an outcome is considered an acquittal.

(11) The SI has potentially disqualifying abuse as determined from abuse investigation reports which have an outcome of founded, substantiated, or valid and in which the SI is determined to have been responsible for the abuse. For the following SIs, potentially disqualifying abuse includes:

(a) For SIs associated with child foster homes licensed by the Department's DD programs, child foster or adoptive homes certified through the Department's Child Welfare Division, child foster or adoptive homes governed by OAR chapter 413 division 215:

(A) Child protective services history held by the Department or OAAPI regardless of the date of initial report;

(B) Child protective services history reviewed pursuant to the federal Adam Walsh Act requirements, determined by BCU to be potentially disqualifying; and

(C) Adult protective services investigations of physical abuse, sexual abuse, or financial exploitation initiated on or after January 1, 2010, as provided to BCU by OAAPI and APD programs based on severity.

(b) For staff, volunteers, or contractors of a child-caring agency, an ISRS program, a SPRF provider, or a System of Care contractor providing child welfare services pursuant to ORS Chapter 418, potentially disqualifying abuse includes:

(A) Child protective services history held by the Department or OAAPI regardless of the date of initial report; and

(B) Adult protective services investigations of physical abuse, sexual abuse, or financial exploitation initiated on or after January 1, 2010, as provided to BCU by OAAPI and APD based on severity.

(c) For child care providers and associated subject individuals defined in OAR 407-007-0210:

(A) Child protective services history held by the Department or OAAPI regardless of the date of initial report, date of outcome, and considered potentially disqualifying pursuant to OAR 461-165-0420; and

(B) Adult protective services investigations of physical abuse, sexual abuse, or financial exploitation initiated on or after January 1, 2010, as provided to BCU by the OAAPI and APD programs based on severity.

(d) For all other SIs, potentially disqualifying abuse includes founded or substantiated adult protective services investigations of physical abuse, sexual abuse, or financial exploitation initiated on or after January 1, 2010, as provided to the BCU by OAAPI and APD programs based on severity.

(12) The SI has child protective services investigations open or pending through the Department or OAAPI as of the date the background check request was electronically submitted to BCU through CRIMS or the date BCU conducted a criminal records check due to imminent danger. This potentially disqualifying condition only applies to:

(a) SIs associated with child foster homes licensed by the Department's DD programs, child foster or adoptive homes certified through the Department's Child Welfare Division, child foster or adoptive homes governed by OAR chapter 413 division 215;

(b) Staff, volunteers or contractors of a child-caring agency, an ISRS program, a SPRF provider, or a System of Care contractor, providing child welfare services pursuant to ORS Chapter 418; or

(c) Child care providers and associated subject individuals defined in OAR 407-007-0210.

(13) For an SI who is child-caring agency proctor foster parent, the SI is the individual found responsible for substantiated adult protective services investigation of neglect initiated on or after January 1, 2010, as provided to BCU by OAAPI and APD based on severity.

(14) For an SI who is child-caring agency proctor foster parent, the SI has any restraining order or protective order against the SI.

(15) For an SI who is a child-caring agency proctor foster parent, the SI makes a false statement to the QE or Department, including the provision of materially false information, regarding abuse, restraining orders, or protective orders; , or failure to disclose information regarding abuse, restraining orders, or protective orders. Nondisclosure of unsubstantiated or inconclusive abuse or dismissed restraining orders or protective others, may not be considered a false statement.

Stat. Auth.: ORS 181A.200, 409.027 & 409.050

Stats. Implemented: ORS 181A.195, 181A.200, 409.010, 409.027, 443.004, & OL 2016, chapter 106, section 6

Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04; OMAP 22-2005, f. & cert. ef. 3-29-05; Renumbered from 410-007-0290, DHSD 8-2007, f. 8-31-07, cert. ef. 9-1-07; DHSD 10-2008, f. 12-26-08, cert. ef. 1-1-09; DHSD 2-2009, f. & cert. ef. 4-1-09; DHSD 7-2009, f. & cert. ef. 10-1-09; DHSD 10-2009, f. 12-31-09, cert. ef. 1-1-10; DHSD 10-2010, f. 10-29-10, cert. ef. 10-31-10; DHSD 1-2011(Temp) f. & cert. ef. 4-15-11 thru 10-11-11; DHSD 7-2011(Temp), f. & cert. ef. 10-12-11 thru 11-1-11; DHSD 8-2011, f. 10-28-11, cert. ef. 11-1-11; DHSD 2-2012(Temp), f. & cert. ef. 2-27-12 thru 8-24-12; DHSD 4-2012, f. & cert. ef. 8-1-12; DHSD 1-2013(Temp), f. & cert. ef. 2-5-13 thru 8-2-13; DHSD 3-2013, f. & cert. ef. 8-1-13; DHSD 2-2014, f. & cert. ef. 12-1-14; DHSD 1-2015(Temp), f. & cert. ef. 2-3-15 thru 8-1-15; DHSD 4-2015, f. 7-31-15, cert. ef. 8-1-15; DHSD 1-2016(Temp), f. & cert. ef. 1-14-16 thru 7-11-16; DHSD 5-2016, f. 6-10-16, cert. ef. 6-15-16; DHSD 6-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-007-0320

Final Fitness Determinations

BCU shall make a final fitness determination pursuant to OAR 125-007-0260 after all necessary background checks have been received and a weighing test, if necessary, has been completed.

(1) The final fitness determination results in one of the following outcomes:

(a) BCU may approve an SI if:

(A) The SI has no potentially disqualifying convictions or potentially disqualifying conditions; or

(B) The SI has potentially disqualifying convictions or potentially disqualifying conditions and, after a weighing test, BCU determines that more likely than not, the SI poses no risk to the physical, emotional, or financial well-being of vulnerable individuals.

(b) BCU may approve an SI with restrictions if BCU determines that more likely than not, the SI poses no risk to the physical, emotional, or financial well-being of vulnerable individuals if certain restrictions are placed on the SI. Restrictions may include but are not limited to restrictions to one or more specific clients, job duties, or environments. A new background check and fitness determination shall be completed on the SI before removing a restriction.

(c) BCU shall deny an SI who the BCU determines, after a weighing test, more likely than not poses a risk to the physical, emotional, or financial well-being of vulnerable individuals.

(d) In the following situations the SI shall have no hearing rights and BCU shall consider a background check to have an outcome of incomplete fitness determination:

(A) The QE or SI discontinues the application or fails to cooperate with the criminal records check or fitness determination process, including but not limited to failure to disclose all requested criminal, abuse or other information, refusal to be fingerprinted or failing to respond in a timely

manner to written correspondence from BCU. The background check request is considered closed.

(B) BCU determines that the SI is ineligible due to ORS 443.004 in accordance with OAR 407-007-0275 or 407-007-0277. The background check request is considered completed.

(C) BCU or the QE withdraws or closes the background check request before a final fitness determination for any reason. The background check request is considered closed.

(D) The SI withdraws the application, leaves the position prior to completion of the background check, or the Department cannot locate or contact the SI. The background check request is considered closed.

(E) The SI is determined to be ineligible for the position by the QE for reasons other than the background check. The background check request is considered closed.

(F) The SI is a child-caring agency proctor foster parent and fails to provide a release of information, the background check request is considered closed.

(e) BCU shall make the fitness determination of mandatory exclusion if the SI is subject to OAR 407-007-0279. If the SI has a conviction or condition listed, the background check request is considered completed. The SI has hearing rights only if granted under federal law.

(f) BCU shall issue an intent to deny if the fitness determination is made under OAR 407-007-0335. The SI has expedited hearings rights under OAR 407-007-0335.

(2) Upon completion of a final fitness determination, BCU or the QE shall provide notice to the SI.

(a) If approved, BCU shall provide notice to the QE through CRIMS. The QE shall provide the SI a copy of the notice or CRIMS documentation.

(b) If the final fitness determination is a denial based on potentially disqualifying abuse under OAR 407-007-0290(11)(d) and there are no other potentially disqualifying convictions or conditions, BCU shall issue a Notice of Denial.

(c) Except as required by section (4)(a) of this rule, if denied or approved with restrictions, BCU shall issue a notice of fitness determination to the SI which includes the potentially disqualifying convictions or conditions that the outcome was based upon, information regarding appeal rights, and the notice becoming a final order in the event of a withdrawal or failure to appear at the hearing.

(d) The effective date of action shall be recorded on the notice or CRIMS documentation.

(3) BCU shall provide the QE notification of the final fitness determination when the SI is being denied or approved with restrictions.

(4) When an SI is denied, the SI shall not be allowed to work, volunteer, be employed, or otherwise perform in the position listed on the background check request. A denial applies only to the position and application in question. A denial shall result in immediate termination, dismissal, or removal of the SI.

(5) When an SI is approved with restrictions, the SI shall only be allowed to work, volunteer, be employed, or otherwise perform in the position listed on the background check request and only under the stated restrictions. A restricted approval applies only to the position and application in question. A restricted approval shall result in immediate implementation of the restrictions.

(6) BCU shall maintain any documents obtained or created during the background check process.

(7) BCU shall make new fitness determinations for each background check request. The outcome of previous fitness determinations does not set a precedent for subsequent fitness determinations.

Stat. Auth.: ORS 181A.200, 409.027 & 409.050

Stats. Implemented: ORS 181A.195, 181A.200, 409.010, 409.027, 443.004, & OL 2016, chapter 106, section 6

Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04; OMAP 22-2005, f. & cert. ef. 3-29-05; Renumbered from 410-007-0320, DHSD 8-2007, f. 8-31-07, cert. ef. 9-1-07; DHSD 10-2008, f. 12-26-08, cert. ef. 1-1-09; DHSD 2-2009, f. & cert. ef. 4-1-09; DHSD 7-2009, f. & cert. ef. 10-1-09; DHSD 10-2009, f. 12-31-09, cert. ef. 1-1-10; DHSD 10-2010, f. 10-29-10, cert. ef. 10-31-10; DHSD 1-2011(Temp) f. & cert. ef. 4-15-11 thru 10-11-11; DHSD 7-2011(Temp), f. & cert. ef. 10-12-11 thru 11-1-11; DHSD 8-2011, f. 10-28-11, cert. ef. 11-1-11; DHSD 2-2012(Temp), f. & cert. ef. 2-27-12 thru 8-24-12; DHSD 4-2012, f. & cert. ef. 8-1-12; DHSD 3-2013, f. & cert. ef. 8-1-13; DHSD 1-2016(Temp), f. & cert. ef. 1-14-16 thru 7-11-16; DHSD 5-2016, f. 6-10-16, cert. ef. 6-15-16; DHSD 6-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Changes to Investigation of Reported Abuse in Certain Child-Caring Agencies Rules
Adm. Order No.: DHSD 7-2016(Temp)
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Adopted: 407-045-0825, 407-045-0885, 407-045-0895, 407-045-0955
Rules Amended: 407-045-0800, 407-045-0820, 407-045-0890, 407-045-0910, 407-045-0940, 407-045-0950, 407-045-0980
Rules Suspended: 407-045-0810, 407-045-0830, 407-045-0850, 407-045-0860, 407-045-0870, 407-045-0880, 407-045-0900, 407-045-0920, 407-045-0930, 407-045-0960, 407-045-0970
Subject: The Department of Human Services (Department) needs to immediately adopt, amend, and repeal rules in OAR 407-045-0800 through 407-045-0980 to comply with Oregon Laws 2016, chapter 106. The intent of this legislation is to enhance safety of children in child-caring agencies, align abuse definitions with paid caregiving expectations, define investigation outcomes, and improve communication within the Department. The proposed temporary rules outline the child-caring agencies in which The Department's Office of Adult Abuse Prevention and Investigations (OAAPI) investigates allegations of abuse and establishes requirements for OAAPI screeners and investigators when allegations of abuse are received in these settings. The rules require immediate screening and investigation of reports alleging child abuse in a child-caring agency, changes the definition of a child to include those up to the age of 21 if they are receiving care or services from a child-caring agency, requires OAAPI investigators and screeners to notify appropriate Department personnel to ensure notifications required by SB 1515 are made, and requires OAAPI to collaborate with appropriate personnel to share information and determine the appropriate Department response to ensure child safety. The Department must implement these changes by July 1, 2016 in order to comply with the law.

Proposed rules are available on the Department of Human Services website: http://www.oregon.gov/DHS/POLICIES/Pages/ss-admin-rules.aspx. For hardcopy requests, call: (503) 947-5250.
Rules Coordinator: Jennifer Bittel—(503) 947-5250

407-045-0800
Purpose and Applicability

(1) The purpose of OAR 407-045-0800 to 407-045-0980 is to describe the responsibility of the Office of Adult Abuse Prevention and Investigations (OAAPI) to investigate reports of abuse in certain Child-Caring Agencies (CCA). These rules govern reports of abuse or neglect in which the CCA, CCA employees or their staff, or proctor foster parent is reported to be responsible. All such reports shall be investigated by OAAPI. Every child deserves safe, respectful, and dignified treatment provided in a caring environment. All CCAs and proctor foster parent(s) shall conduct themselves in such a manner that every child is free from abuse.

(2) These rules apply to the following CCA entities:

(a) Children's residential care agencies;

(b) Day treatment programs as defined in OAR chapter 413, division 215;

(c) Therapeutic boarding schools as defined in OAR chapter 413, division 215;

(d) Foster care agencies and proctor foster parents certified by the CCA; and

(e) Outdoor youth programs as defined in OAR chapter 413, division 215.

(3) Nothing in these rules relieves any mandatory reporter, including a CCA or proctor foster parent, from reporting abuse alleged to have been caused by other individuals, including but not limited to family members.

Stat. Auth.: ORS 409.050, 418.005 & 418.189

Stats. Implemented: ORS 418.189 & 418.205–418.327, 409.185, 418.015, 419B.005-419B.050 & OL 2016, Ch 106

Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0810
General Policy and Applicability

(1) Every child deserves safe, respectful, and dignified treatment provided in a caring environment. All CCPs governed by these rules, and their staff, shall conduct themselves in such a manner that children are free from abuse.

(2) In these rules, the term "abuse" is defined in some detail because of the unique vulnerabilities of children served by CCPs and the nature of

the settings where abuse may occur. All forms of abuse are prohibited. CCPs and their staff must always be aware of the potential for abuse in interactions with children.

(3) These rules govern reports of abuse or neglect in which the CCP, or its staff, is reported to be responsible. All such reports shall be investigated by the Department of Human Services's (Department) Office of Investigations and Training (OIT).

(4) OIT shall evaluate each case based on available facts and on the individual circumstances of the child, including the child's particular vulnerabilities.

(5) Nothing in these rules relieves any mandatory reporter, including a CCP, from reporting abuse or neglect alleged to have been caused by other individuals, including but not limited to family members. Those reports shall continue to be investigated by the Department's Children, Adults and Families Division (CAF) or by law enforcement.

Stat. Auth: ORS 409.050, 418.005 & 418.189
Stats. Implemented: ORS 418.189 & 418.205 – 418.327
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0820
Definitions

The following definitions apply to OAR 407-045-0800 through 407-045-0980:

(1) "Abuse" means one or more of the following:

(a) Abandonment, including desertion or willful forsaking of a child in care or the withdrawal or neglect of duties and obligations owed a child in care by a child-caring agency, caretaker or other person.

(b) Involuntary seclusion of a child in care for the convenience of a child-caring agency or caretaker or to discipline the child in care.

(c) A wrongful use of a physical or chemical restraint of a child in care, excluding an act of restraint prescribed by a physician licensed under ORS Chapter 677 and any treatment activities that are consistent with an approved treatment plan or in connection with a court order.

(d) Financial exploitation.

(A) Financial exploitation includes:

(i) Wrongfully taking the assets, funds or property belonging to or intended for the use of a child in care.

(ii) Alarming a child in care by conveying a threat to wrongfully take or appropriate moneys or property of the child in care if the child would reasonably believe that the threat conveyed would be carried out.

(iii) Misappropriating, misusing or transferring without authorization any moneys from any account held jointly or singly by a child in care.

(iv) Failing to use the income or assets of a child in care effectively for the support and maintenance of the child in care.

(B) Financial exploitation does not include age-appropriate discipline that may involve the threat to withhold, or the withholding of, privileges.

(e) Neglect of a child in care. Neglect includes:

(A) Failure to provide the care, supervision or services necessary to maintain the physical and mental health of a child in care; or

(B) The failure of a child-caring agency, proctor foster home, caretaker or other person to make a reasonable effort to protect a child in care from abuse.

(f) Physical abuse of a child in care. Physical abuse includes:

(A) Any physical injury to a child in care caused by other than accidental means, or which appears to be at variance with the explanation given of the injury.

(B) Willful infliction of physical pain or injury upon a child in care.

(g) Sexual abuse. Sexual abuse includes:

(A) Sexual harassment, sexual exploitation or inappropriate exposure to sexually explicit material or language;

(B) Any sexual contact between a child in care and an employee of a child-caring agency or proctor foster home, caretaker or other person responsible for the provision of care or services to a child in care;

(C) Any sexual contact between a person and a child in care that is unlawful under ORS chapter 163 and not subject to a defense under that chapter; or

(D) Any sexual contact that is achieved through force, trickery, threat or coercion.

(E) An act that constitutes a crime under ORS 163.375, 163.405, 163.411, 163.415, 163.425, 163.427, 163.465, 163.467 or 163.525.

(h) Verbal abuse. Verbal abuse means to threaten physical or emotional harm to a child in care through the use of:

(A) Derogatory or inappropriate names, insults, verbal assaults, profanity or ridicule; or

(B) Harassment, coercion, threats, intimidation, humiliation, mental cruelty or inappropriate sexual comments.

(2) "Child" means an unmarried individual under 21 years of age.

(3) "Child-caring agency" is defined in ORS 418.205 and means:

(a) Any private school, private agency or private organization that provides:

(A) Day treatment for children with emotional disturbances;

(B) Adoption placement services;

(C) Residential care, including but not limited to foster care or residential treatment for children;

(D) Residential care in combination with academic education and therapeutic care, including but not limited to treatment for emotional, behavioral or mental health disturbances;

(E) Outdoor youth programs; or

(F) Other similar care or services for children.

(b) Includes the following:

(A) A shelter-care home that is not a foster home subject to ORS 418.625 to 418.645;

(B) An independent residence facility as described in ORS 418.475;

(C) A private residential boarding school; and

(D) A child-caring facility as defined in ORS 418.950.

(c) Child-caring agency does not include:

(A) Residential facilities or foster care homes certified or licensed by the Department of Human Services under ORS 443.400 to 443.455, 443.830 and 443.835 for children receiving developmental disability services;

(B) Any private agency or organization facilitating the provision of respite services for parents pursuant to a properly executed power of attorney under ORS 109.056. For purposes of this section, respite services means the voluntary assumption of short-term care and control of a minor child without compensation or reimbursement of expenses for the purpose of providing a parent in crisis with relief from the demands of ongoing care of the parent's child;

(C) A youth job development organization as defined in ORS 344.415;

(D) A shelter-care home that is a foster home subject to ORS 418.625 to 418.645; or

(E) A foster home subject to ORS 418.625 to 418.645.

(4) "Child in care" means an unmarried individual who is under 21 years of age who is residing in or receiving care or services from a child-caring agency or proctor foster home that is subject to ORS 418.205, 418.327, 418.470, 418.475, 418.950 and 418.970.

(5) "Department" means the Department of Human Services.

(6) "Designated medical professional" means a medical professional as defined in ORS 418.747 who has been trained to conduct child abuse medical assessments pursuant to 418.782.

(7) "Inconclusive" means there is some indication that the abuse of a child in care occurred, but there is insufficient evidence to conclude that there is reasonable cause to believe that the abuse occurred.

(8) "Intimidation" means compelling or deterring conduct by threat. Intimidation does not include age-appropriate discipline that may involve the threat to withhold privileges.

(9) "Law enforcement agency" means:

(a) Any city or municipal police department;

(b) Any county sheriff's office;

(c) The Oregon State Police;

(d) Any district attorney;

(e) A police department established by a university under ORS 352.121 or 353.125.

(10) "Legal finding" means a court or administrative finding, judgment, order, stipulation, plea, or verdict.

(11) "OAAPI" means the Department's Office of Adult Abuse Prevention and Investigations.

(12) "OAAPI investigator" means a Department employee who is authorized and receives OAAPI approved training to screen or investigate allegation of abuse under these rules.

(13) "OAAPI Substantiation Review Committee (OSRC)" means a group of three Department employees selected by the Department's Deputy Director or designee, none of whom was involved in any part of the investigation that resulted in the OAAPI substantiation under review. The committee shall consist of Department employees who are knowledgeable about the dynamics of child abuse and neglect, including the assessment or investigation of child abuse, and Department employees with knowledge of abuse investigations, especially where abuse is alleged to have occurred in out-of-home settings.

(14) "Person with substantiated abuse" means the person OAAPI has reasonable cause to believe is responsible for abuse of a child in care under these rules, and about whom a substantiated finding has been made.

(15) "Proctor foster home" means a foster home certified by a child-caring agency under Oregon Laws 2016, chapter 106, section 6 that is not subject to ORS 418.625 to 418.645.

(16) "Services" includes but is not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene or any other service essential to the well-being of a child in care.

(17) "Sexual contact" has the meaning given that term in ORS 163.305 (1)(a)(E).

(18) "Sexual exploitation" as described in ORS 419B.005 (1)(a)(E).

(19) "Substantiated" means there is reasonable cause to believe that abuse of a child in care occurred.

(20) "Suspicious physical injury" is defined in ORS 419B.023 (1)(B) and includes but is not limited to:

(a) Burns or scalds;

(b) Extensive bruising or abrasions on any part of the body;

(c) Bruising, swelling, or abrasions on the head, neck, or face;

(d) Fractures of any bone of a child in care under the age of three;

(e) Multiple bone fractures of a child in care;

(f) Dislocations, soft tissue swelling, or moderate to severe cuts;

(g) Loss of the ability to walk or move normally according to the child's developmental ability;

(h) Unconsciousness or difficulty maintaining consciousness;

(i) Multiple injuries of different types;

(j) Injuries causing serious or protracted disfigurement or loss or impairment of the function of any bodily organ; or

(k) Any other injury that threatens the physical well-being of the child in care.

(21) "Unsubstantiated" means there is no evidence that the abuse of a child in care occurred.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 409.185, 418.005, 418.189, 418.205 - 418.327, 418.747, 418.751, 419B.005 - 419B.050 & OL 2016, Ch 106
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; DHSD 6-2010(Temp), f. & cert. ef. 7-12-10 thru 1-8-11; DHSD 12-2010, f. 12-30-10, cert. ef. 1-1-11; DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0825
Screening Reports of Abuse

(1) Within 24 hours of receiving a report of abuse, OAAPI shall determine if:

(a) The report meets the definition of abuse of a child in care as defined by OAR 407-045-0820;

(b) The CCA is listed in OAR 407-045-0800(2) or is a CCA certified proctor foster parent;

(c) The CCA, CCA employees, volunteers, contractors or their employees or their staff, or proctor foster home parent, is suspected or reported as responsible for the alleged abuse;

(d) The alleged victim of abuse is a child in care as defined by OAR 407-045-0820.

(2) If OAAPI determines the report of alleged abuse meets the conditions listed in section (1) of this rule, the report shall be assigned for immediate investigation.

(3) In instances where a child in care is reported to be in need of immediate protection or a condition exists which places other children at risk, OAAPI shall collaborate with law enforcement and Department personnel or other appropriate entities to ensure child safety is provided.

(4) If an OAAPI screener becomes aware of conditions that do not constitute abuse as defined by this rule and ORS 419B.005, but may pose a risk to the health, safety, or welfare of a child, including possible licensing violations or inadequate living conditions or access to food and personal supplies, the OAAPI screener shall make a report to Department personnel designated to accept such reports and make notifications as defined in OAR 407-045-0895.

(5) If OAAPI determines the report of alleged abuse does not meet the conditions listed in section (1) of this rule, the report shall be closed at screening. Supervisor approval is required prior to closing a report at screening.

(6) OAAPI shall document the information supporting the decision to either assign a report for investigation or close a report at screening.

(7) OAAPI shall immediately make all applicable cross reports and notifications as described in OAR 407-045-0895 and shall send the screening report to the Department personnel designated to make notifications required by Oregon Laws 2016, chapter 106 and OAR 413-080-0070.

(8) The OAAPI Director or designee may grant an extension of an additional 24 hours to the 24 hour screening deadline if critical information, such as the child's location, is still needed to determine the Department response. The screener shall document in the Department's electronic information system the reason for the extension, including the critical information that remains to be collected, and the Director or designee's approval. Such an extension does not relieve the Department of the responsibility to make notifications as described in 407-045-0895.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005, 418.205-418.327, 419B.015, 419B.017, 419B.020 & OL 2016, Ch 106
Hist.: DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0830
Training of Children's Care Providers

(1) The Department shall provide training and consultation to CCPs to identify abuse and to prevent abuse from occurring.

(2) The Department shall provide training to assist CCPs to understand the abuse investigation process and the CCP's responsibility in cooperating with the investigation.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.189 & 418.702
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0850
Responsibilities of the CCP

(1) CCPs and their staff are mandatory reporters governed by ORS 419B.005 to 419B.050. Mandatory reporters must immediately report when they have reasonable cause to believe any child with whom they have come in contact has suffered abuse or that any person with whom they have come in contact has abused a child. For purposes of reporting, the belief need only be a reasonable suspicion, and does not need to rise to the level of probable cause. All reports must be made verbally or in writing to the Department or to a law enforcement agency within the county where the individual making the report is located at the time of the contact.

(2) Concurrent with reporting the suspected abuse or neglect of a child, CCPs shall immediately assess the safety of the child and take any action necessary to remove the child from danger and keep the child safe. CCPs shall cooperate with OIT in establishing a safety plan for the child who is the subject of the report, and for other children who may be at risk of abuse or neglect. In establishing a safety plan, CCPs may not take any actions beyond determining:

(a) Whether the alleged victim is in danger or in need of immediate protective services, in light of the nature of the report; and

(b) Whether any immediate personnel action needs to be taken.

(c) When taking protective action as described in section (2) above, the CCP may not conduct an internal investigation without prior authorization from OIT. For purposes of this section, a prohibited internal investigation includes:

(A) Interviews with the alleged victim, witnesses, the accused person, or any other individual or witness who may have knowledge of the facts of the abuse allegation or related circumstances that include questions beyond those necessary for immediate protection of the child or other children; or

(B) Review of relevant evidence, other than the initial report or other documents necessary for immediate protection of the child or other children.

(3) CCPs shall document all reports of suspected abuse or neglect of a child including, to the extent possible, the following information:

(a) The name, age, and present location of the child;

(b) The names and addresses of individuals, programs, or facilities responsible for the child's care;

(c) The nature and extent of the alleged abuse;

(d) Any information that led the individual making the report to suspect abuse had occurred;

(e) Any information that the individual believes might aid in establishing the cause of the abuse and the identity of the individual alleged to be responsible for the abuse; and

(f) The date of the incident.

(4) Every CCP shall cooperate fully with OIT under these rules. Cooperation includes but is not limited to:

(a) Providing the investigator with access to the child, the facility, and to all potential witnesses; and

(b) Producing all records and reports requested, including but not limited to medical, psychiatric and psychological records and reports, and individual service or behavioral support plans for the child.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 419B.010–419B.015
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0860
Responsibilities of the Office of Investigations and Training

(1) When OIT receives a report of abuse, OIT shall notify a law enforcement agency within the county where the report was made. If the abuse is reported to have occurred in a different county, OIT must also cross-report to the law enforcement agency in the county where the reported abuse occurred.

(2) OIT shall cross-report to law enforcement on the same day the OIT screener determines the report requires an immediate or a 24-hour response.

(a) Required same day cross-reports include but are not limited to reports of moderate to severe physical abuse, visible injuries to a child, sexual abuse, or the suspicious or unexpected death of a child. Same day reports may be cross-reported verbally, by electronic transmission, or by hand delivery.

(b) When a cross-report is verbal and OIT and law enforcement do not respond to the report together, OIT must send a completed screening report to law enforcement.

(3) All other reports, including those investigated at screening but closed, must be cross-reported to law enforcement no later than ten days after the Department receives the report. The cross-report may be made by electronic transmission, hand delivery, or regular mail.

(4) When OIT receives a report of alleged abuse or neglect, OIT shall notify the child's parent or legal guardian that an allegation has been made, unless notice is prohibited by law or court order or would compromise the child's safety or a criminal investigation. If the child is in the legal custody of the Department, OIT shall notify the child's assigned Department caseworker, if notice has not already been provided. If the child has been placed at the CCP through the Oregon Youth Authority (OYA), OIT shall notify OYA. If OIT has reason to believe the child is an Indian child, OIT shall notify the tribe within 24 hours from the time the report was received by the Department. In cases in which OIT finds reasonable cause to believe that a child has died as a result of abuse or where the death occurred under suspicious or unknown circumstances, OIT shall notify the appropriate law enforcement agency.

Stat. Auth: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005 & 419B.005 - 419B.050
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0870
Office of Investigations and Training Screening Decision Time Frames

(1) When the information received constitutes a report of abuse in which a child may be unsafe, OIT shall interview the child, conduct a site visit, or coordinate with CCP staff to assure that the child is safe within 24 hours after the report is received. If OIT plans to interview the child, OIT must notify the child's parent or legal guardian, unless notification is prohibited by law or court order or would compromise the child's safety or a criminal investigation.

(2) When it has not been reported that the child is unsafe and there are no other indicators the child is unsafe, OIT may decide to open the case for investigation or to close it at screening. OIT must make the decision to open or close the case within five calendar days from the date the report is received by the Department. The OIT screener may request approval for an extension of time beyond five days if extenuating circumstances exist. Extensions may only be granted by the OIT Director or the Director's designee.

(3) OIT shall screen all reports to identify the nature and cause of the reported abuse.

(a) In all cases, the screener shall evaluate whether the child is safe or unsafe, assess the need for protective action, request that protective action be taken and necessary services provided, and assess the need for further investigation.

(b) In conducting the screening process, OIT may:

(A) Coordinate in-person or by telephone with any CCP staff authorized to take protective action on behalf of the child;

(B) Conduct a site visit at the CCP;

(C) Interview the child or other witnesses;

(i) Prior to interviewing a child victim or child witness, OIT shall give notice of its intent to interview to the child's legal guardian, unless notice is prohibited by law or court order, or would compromise the child's safety or a criminal investigation.

(ii) If OIT determines contact with the child should occur at the child's school, OIT shall comply with the requirements of ORS 419B.045.

(D) Gather and secure physical evidence as necessary;

(E) Take photographs of the child and obtain a medical assessment, as necessary, consistent with OAR 407-045-0880(2)(d) and (e) of this rule;

(F) Take photographs of the facility as necessary or appropriate; and

(G) Receive, review, or copy records pertaining to the child or the incident, including but not limited to incident reports, evaluations, treatment or support plans, treatment notes or progress records, or other documents concerning the welfare of the child.

(4) If OIT decides the information received does not constitute a report of child abuse or neglect as defined in these rules, the report shall be closed at screening. If the report is closed at screening, the screener shall document the information supporting the decision to close. If the child is in the legal custody of the Department, OIT shall notify the child's assigned caseworker of the decision to close the case. If the child has been placed in the CCP by OYA, OIT shall notify OYA. OIT shall notify the CCP and the individual who made the report that the report has been closed. All notices of the decision to close shall be made within three days of the decision.

(5) If, after screening, OIT determines that the information constitutes a report of child abuse or neglect under these rules, it shall open the case for investigation. If OIT decides to investigate, OIT shall immediately notify the child's legal guardian, unless notification is prohibited by law or by court order, or could compromise the child's safety or a criminal investigation. OIT shall also notify the child's caseworker if the child is in the legal custody of the Department and shall notify OYA or the child's tribe, as applicable.

(6) Whenever an OIT investigator takes photographs of physical injuries to a child who is in the custody of the Department, the investigator shall promptly forward copies of the photographs to the CAF caseworker assigned to the child. When conducting screenings or investigations in foster home settings, the investigator shall ascertain whether any other children living in the foster home are in the custody of the Department and if so, shall notify each child's caseworker that a report of abuse or neglect in the foster home is being investigated or screened, and the nature of the investigation.

Stat. Auth: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005, 419B.015, 419B.017 & 419B.020
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0880
OIT Investigative Process in Cases Opened for Investigation

(1) OIT shall conduct thorough and unbiased investigations of abuse allegations.

(2) In conducting abuse investigations, the OIT investigator shall:

(a) Make in-person contact with the child;

(b) Interview the child, any witnesses, the accused person, and other individuals who may have knowledge of the facts of the abuse allegation or related circumstances;

(c) Review all relevant and material evidence;

(d) Take photographs as appropriate or necessary. If the investigator observes a child who has suffered a suspicious physical injury and the investigator has a reasonable suspicion that the injury may be the result of abuse, the investigator must immediately photograph or have photographed the suspicious physical injury, pursuant to ORS 418.747; and

(e) If the investigator observes a child who has suffered a suspicious physical injury and the investigator has a reasonable suspicion that the injury may be the result of abuse, the investigator must, pursuant to ORS 418.747, ensure that a designated medical professional conducts a medical assessment within 48 hours of the observation, or sooner if dictated by the child's medical needs. If a designated medical professional is not available, the investigator must ensure that an available physician conducts the medical assessment. The investigator must document the efforts made to locate the designated medical professional.

(3) A person accused of abuse may have a peer consultant present during the OIT interview. Any individual providing peer support shall be obligated to maintain the confidentiality of information declared to be confidential under state or federal law. Peer supporters shall not be involved in the investigation as witnesses or potential witnesses. CCP certification or human resources staff shall not serve as peer supporters. An accused person wishing to have a peer supporter present during the interview shall notify

the OIT investigator in advance of the scheduled interview and shall provide the investigator with the peer's name and job title.

(4) When a law enforcement agency is conducting an investigation of the alleged abuse, the OIT investigator shall cooperate with the law enforcement agency. When a law enforcement agency is conducting a criminal investigation of the alleged abuse, OIT may also conduct its own investigation, as long as it does not interfere with the law enforcement agency investigation, when:

(a) There is potential for action by a licensing agency;

(b) Timely investigation by law enforcement is not likely; or

(c) When the law enforcement agency does not complete a criminal investigation.

(5) During the investigation, if the investigator knows or has reason to believe the child is an Indian child, the investigator must give notice to the child's tribe within 24 hours that an investigation is being conducted, if the tribe has not already been notified.

Stat. Auth.: ORS 409.050 & 418.005

Stats. Implemented: ORS 409.185, 418.005, 418.747, 419B.045 & 419B.005-419B.050

Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0885

Investigating Reports of Abuse

(1) OAAPI shall conduct thorough and unbiased investigations of abuse allegations.

(2) In conducting abuse investigations, the OAAPI investigator or designee shall:

(a) Make in-person contact with the child in care who is the alleged victim of the suspected abuse within 24 hours of the investigation being assigned.

(b) During the investigation, if the investigator knows or has reason to believe the child in care is an Indian child, the investigator or designee shall give notice to the child's tribe within 24 hours that an investigation is being conducted, if the tribe has not already been notified.

(c) If an investigator believes a child in care is in need of immediate protection or a condition exists which places the child or other children at risk, the investigator shall collaborate with law enforcement, Department personnel or other appropriate entities to ensure child safety.

(d) Interview the child in care, any witnesses, the person accused or person responsible for the agency accused of abuse, and other individuals who may have knowledge of the facts of the abuse allegation or related circumstances. The OAAPI investigator shall conduct in-person interviews where practicable.

(e) The interviewee shall be informed that they may decline to be interviewed and should be interviewed in a place and manner that allows them to leave or terminate the interview at any time.

(A) OAAPI may interview witnesses and the child in care who is the subject of suspected abuse without the presence of child-caring agency employees, proctor foster parent or Department personnel.

(B) Prior to interviewing any child in care, OAAPI shall notify the child's parent or legal guardian, unless notification is prohibited by law or court order, or would compromise the child's safety or a criminal investigation.

(C) When OAAPI interviews a child in care, the child shall be informed they have a right to decline the interview and may have present:

(i) The child in care's parent or guardian, if the child has not been committed to the custody of the Department or the Oregon Youth Authority (OYA), or

(ii) The child in care's attorney.

(D) The interview should be held in a place and manner that the child is free to leave or terminate the interview.

(E) If OAAPI determines contact with the child in care should occur at the child's school, OAAPI shall comply with the requirements of ORS 419B.045.

(f) A person accused of abuse may have a peer consultant present during the OAAPI interview. Any individual providing peer support shall be obligated to maintain the confidentiality of information declared to be confidential under state or federal law. Peer supporters shall not be involved in the investigation as witnesses or potential witnesses. CCA certification or human resources staff shall not serve as peer supporters. A person accused of abuse wishing to have a peer supporter present during the interview shall notify the OAAPI investigator in advance of the scheduled interview and shall provide the investigator with the peer's name and job title.

(g) Obtain and review all relevant and material evidence, which includes but is not limited to:

(A) Conducting a site visit at the CCA or proctor foster parent;

(B) Gathering and securing physical evidence as necessary; and

(C) Receiving, reviewing, or copying records pertaining to the child in care or the incident, including but not limited to incident reports, evaluations, treatment or support plans, treatment notes or progress records, or other documents concerning the welfare of the child.

(h) Take photographs as appropriate or necessary.

(3) If the investigator observes a child in care who has suffered a suspicious physical injury and the investigator has a reasonable suspicion that the injury may be the result of abuse, the investigator shall:

(a) Pursuant to ORS 418.747, immediately photograph or have photographed the suspicious physical injury pursuant to ORS 419B.023, unless the child is age 18 or older and exercises their right to decline being photographed; and

(b) Pursuant to ORS 418.747 and 419B.023, ensure that a designated medical professional conducts a medical assessment within 48 hours of the observation, or sooner if dictated by the child in care's medical needs. If a designated medical professional is not available, the investigator shall ensure that an available physician, physician's assistant or nurse practitioner conducts the medical assessment. The investigator shall document the efforts made to locate the designated medical professional.

(c) Whenever an OAAPI investigator takes photographs of physical injuries of a child in care who is in the custody of the Department, the investigator shall promptly forward copies of the photographs to the Department's Child Welfare caseworker assigned to the child.

(4) When a law enforcement agency is conducting an investigation of the alleged abuse, the OAAPI investigator shall cooperate with the law enforcement agency. When a law enforcement agency is conducting a criminal investigation of the alleged abuse, OAAPI shall also conduct its own investigation, as long as it does not interfere with the law enforcement agency investigation.

(5) During the course of the investigation, the OAAPI investigator shall coordinate with others in the Department, including but not limited to the Office of Licensing and Regulatory Oversight, the Child Welfare Well Being Unit, a child protective service worker assigned to investigate abuse of the child in care, and the child in care's Child Welfare caseworker if the child is in the custody of the Department.

(6) When the OAAPI investigation is complete, OAAPI shall issue a final abuse investigation report as described in OAR 407-045-0890 stating whether the allegation is substantiated, unsubstantiated, or inconclusive.

(7) Upon issuance of a final decision, OAAPI shall send the report described in OAR 407-045-0890 to the Department personnel designated to make notifications required by Oregon Laws 2016, chapter 106.

(8) Any deviations from the investigative process shall be staffed and approved by a supervisor. Deviations and approval shall be documented clearly in the investigative report.

(9) If during the course of an investigation and OAAPI investigator becomes aware of conditions that do not constitute abuse as defined by this rule and ORS 419B, but may pose a risk to the health, safety, or welfare of a child, including possible licensing violations or inadequate living conditions or access to food and personal supplies, the OAAPI investigator shall make a report to Department personnel designated to accept such reports and make notifications and take actions as required in Oregon Laws 2016, chapter 106 and OAR 413-080-0070.

Stat. Auth.: ORS 409.050 & 418.005

Stats. Implemented: ORS 409.185, 418.005, 418.205 - 418.327, 418.747, 419B.045, 419B.005-419B.050 & OL 2016, Ch 106

Hist.: DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0890

Abuse Investigation Report

(1) When the investigation is complete, OAAPI shall prepare a written report that includes the following:

(a) A description of the allegation of abuse being investigated, including the date, location and time (if known);

(b) An outline of steps taken in the investigation, a list of all witnesses interviewed, and a summary of the information provided by each witness;

(c) A summary of findings and conclusion concerning the allegation of abuse;

(d) A specific finding of whether the abuse allegation is substantiated, unsubstantiated, or inconclusive;

(e) A list of all individuals and entities who receive the required notices as defined in OAR 407-045-0895;

(f) The name and title of the individual completing the report; and

(g) Documentation that a supervisor, or their designee, has reviewed and approved the completed report.

(2) The report shall be completed within 30 business days from the date the case was assigned for investigation. The OAAPI Director or designee may authorize an extension for good cause shown. Documentation of the date of the extension shall be noted in the report.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 409.185, 409.225, 418.015, 419B.005-050, 419B.035 & OL 2016, Ch. 106
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0895
Cross Reporting and Notifications

(1) OAAPI shall immediately report to law enforcement, if not already done:

(a) Any crime that OAAPI suspects has occurred with respect to a child in care, at a child-caring agency or proctor foster home, even if the suspected crime is not related to a report of abuse made under these rules.

(b) If OAAPI has reasonable cause to believe that a child in care has died as a result of abuse or where the death occurred under suspicious or unknown circumstances.

(c) OAAPI shall notify the law enforcement agency within the city or county where the report was made. If the abuse or crime is reported to have occurred in a different city or county, OAAPI shall also cross-report to the law enforcement agency in the city or county where the reported abuse or crime occurred. Cross-reports to law enforcement agencies may be verbal, by electronic transmission, or by hand delivery.

(2) Unless the Department determines that disclosure is not permitted under ORS 419B.035, OAAPI will notify the reporter, if contact information is available:

(a) Whether contact was made with the child in care;

(b) Whether the Department determined that child abuse or neglect occurred.

(3) The Department shall make all other notifications as required by Oregon Laws 2016, chapter 106 and OAR 413-080-0070.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 409.185, 409.225, 418.005, 418.205 - 418.327, 419B.015, 419B.035 419B.005 - 419B.050 & OL 2016, Ch, 106
Hist.: DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0900
Right to Request Review of a Substantiated Finding of Abuse

(1) When OIT has substantiated that abuse of a child has occurred, the person against whom the finding has been made, or a CCP against whom the finding has been made, has the right to request an administrative review of the OIT decision following the procedure set forth in OAR 407-045-0940.

(2) When OIT issues a substantiated abuse report, OIT shall also include written notice of the right to request an administrative review.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 419B.010 & 419.370
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0910
Notice of a Substantiated Finding of Abuse

(1) When OAAPI has substantiated an allegation of abuse of a child in care, OAAPI shall deliver a notice to the person with substantiated abuse or CCA named in the report. The notice shall be delivered:

(a) By certified mail, restricted delivery, return receipt requested to the last known address of the person with substantiated abuse or CCA; or

(b) By hand delivery to the person with substantiated abuse or CCA. If hand delivered, the notice shall be addressed to the person with substantiated abuse or to the OAAPI contact on record for a CCA and a copy of the notice shall be signed and dated by the person with substantiated abuse or CCA representative acknowledging receipt and signed by the individual delivering the notice.

(2) The notice of an OAAPI substantiation of abuse shall include the following:

(a) The case number assigned to the investigation that resulted in the OAAPI substantiation;

(b) The full name of the person with substantiated abuse or CCA who has been identified as responsible for the abuse as documented in the OAAPI report;

(c) A statement that the OAAPI investigation resulted in a substantiated finding of abuse, including a description of the type of abuse identified;

(d) A description of the OAAPI investigation, including a redacted summary of findings and conclusions;

(e) A statement that the person with substantiated abuse or CCA has a right to request a review;

(f) Instructions for making a request for review, including the requirement that the person with substantiated abuse or CCA provide a full explanation why the person with substantiated abuse or CCA believes the OAAPI substantiation is incorrect.

(g) A statement that the Department may not review an OAAPI substantiation if a legal proceeding is pending and that the person with substantiated abuse or CCA may request a review within 30 calendar days of the resolution of the pending legal proceeding unless the proceeding results in a legal finding that is consistent with the OAAPI substantiation;

(h) A statement that the person with substantiated abuse waives the right to request a review if the request for review is not received by OAAPI within 30 calendar days from the date of the notice of OAAPI substantiation, as documented by a returned receipt.

(i) A statement that the OSRC shall consider relevant documentary information, including the OAAPI report and accompanying exhibits, and information submitted with the request for review by the person with substantiated abuse or CCA requesting review.

(j) A statement that the OSRC may not re-interview the victim; interview the person with substantiated abuse or CCA, with others associated with the person with substantiated abuse or CCA, or with others mentioned in the report; or conduct a field assessment of the allegation of abuse; and

(k) A statement that OAAPI shall send the person with substantiated abuse or CCA a notice of OSRC decision within 60 calendar days of receiving a request for review.

(3) If a person with substantiated abuse or the CCA believes they are entitled to a notice of OAAPI substantiation but has not received one, the person with substantiated abuse or CCA may contact OAAPI to inquire about a review of the disposition.

(4) OAAPI shall determine whether a notice of OAAPI substantiation was delivered to the person with substantiated abuse or CCA or if the person with substantiated abuse or CCA refused delivery of the notice, as evidenced by the returned receipt.

(5) If a notice was delivered to the person with substantiated abuse or CCA or if the person with substantiated abuse or CCA refused delivery of the notice, as evidenced by a returned receipt, and the time for requesting review has expired, OAAPI shall:

(a) Prepare and deliver a notice of waived rights for review; or

(b) Inform the person with substantiated abuse or CCA by telephone of the information required in the notice of waived rights for review. OAAPI shall document the telephone call.

(c) If no return receipt exists or if it appears that notice was not properly provided, OAAPI shall deliver a notice of OAAPI substantiation as provided in these rules.

(6) If a person with substantiated abuse or CCA asks to review Department records for the purpose of reviewing an OAAPI substantiation, state and federal confidentiality laws, including OAR 413-010-0000 to 413-010-0075 and 413-350-0000 to 413-350-0090, govern the inspection and copying of records.

(7) OAAPI shall maintain records to demonstrate the following, when applicable:

(a) Whether the Department delivered a notice of OAAPI substantiation;

(b) Whether the notice of OAAPI substantiation was received by the addressee, as evidenced by a returned receipt documenting that the notice was received, refused, or not received; and

(c) The date a request for review was received by OAAPI.

(8) OAAPI shall maintain a comprehensive record of completed OAAPI substantiation reviews.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005 & OL 2016, Ch 106
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0920
Claim of Lack of Notice

(1) If a person or CCP believes they are entitled to a notice of OIT substantiation but has not received one, the person or CCP may contact OIT to inquire about a review of the disposition.

(2) OIT must determine whether a notice of OIT substantiation was delivered to the person or CCP or if the person or CCP refused delivery of the notice, as evidenced by the returned receipt.

(3) If a notice was delivered to the person or CCP or if the person or CCP refused delivery of the notice, as evidenced by a returned receipt, and the time for requesting review has expired, OIT must:

(a) Prepare and deliver a notice of waived rights for review; or

(b) Inform the person or CCP by telephone of the information required in the notice of waived rights for review. OIT must document the telephone call.

(4) If no return receipt exists or if it appears that notice was not properly provided, OIT must deliver a notice of OIT substantiation as provided in these rules.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0930
Information Included in the Notice of an OIT Substantiation

The notice of an OIT substantiation must include the following:

(1) The case number assigned to the investigation that resulted in the OIT substantiation;

(2) The full name of the person or CCP who has been identified as responsible for the child abuse as recorded in the OIT report;

(3) A statement that the OIT investigation resulted in a substantiation, including a description of the type of child abuse or neglect identified;

(4) A description of the OIT investigation, including a summary of findings and conclusions;

(5) A statement that the person or CCP has a right to request a review;

(6) Instructions for making a request for review, including the requirement that the person or CCP provide a full explanation why the person believes the OIT substantiation is wrong;

(7) A statement that the Department may not review an OIT substantiation if a legal proceeding is pending and that the person or CCP may request a review within 30 calendar days of the resolution of the pending legal proceeding unless the proceeding results in a legal finding that is consistent with the OIT substantiation;

(8) A statement that the person waives the right to request a review if the request for review is not received by OIT within 30 calendar days from the date of the notice of OIT substantiation, as documented by a returned receipt.

(9) A statement that the OSRC shall consider relevant documentary information, including the OIT report and accompanying exhibits, and information submitted with the request for review by the person or CCP requesting review.

(10) A statement that the OSRC may not re-interview the victim; interview or meet with the person or CCP, with others associated with the person or CCP, or with others mentioned in the report; or conduct a field assessment of the allegation of child abuse; and

(11) A statement that OIT shall send the person or CCP a notice of OSRC decision within 60 calendar days of receiving a request for review.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0940
Review of Substantiated Abuse Finding

(1) When OAAPI has determined abuse has occurred, the person with substantiated abuse or a CCA against whom the finding has been made, has the right to request an administrative review of the OAAPI decision.

(2) A person with substantiated abuse or CCA requesting a review shall use information contained in the notice of OAAPI substantiation to prepare a written request for review. The written request for review shall be received by OAAPI within 30 calendar days of the receipt of the notice of OAAPI substantiation. If the request is submitted by mail, it shall be postmarked within 30 calendar days. The request shall include the following:

(a) Date the request for review is written;

(b) Case number found on the notice of OAAPI substantiation;

(c) Full name of the person with substantiated abuse or CCA;

(d) The person with substantiated abuse or CCA's current name (if it has changed from the name noted in section (c) of this rule);

(e) A full explanation, responsive to the information provided in the Department's notice, explaining why the person with substantiated abuse or CCA believes the OAAPI substantiation is wrong and any additional information and documents the person with substantiated abuse or CCA wants considered during the review;

(f) The person with substantiated abuse or CCA's current street address and telephone number; and

(g) The person with substantiated abuse signature or the signature of a CCA employee authorized to sign on behalf of the organization.

(3) Except as provided in OAR 407-045-0950, within 60 calendar days of OAAPI's receipt of a completed request for review, the OSRC shall conduct a review and issue a notice of OSRC decision that includes the following:

(a) Whether there is reasonable cause to believe that abuse occurred;

(b) Whether there is reasonable cause to believe that the person with substantiated abuse or CCA was responsible for the abuse;

(c) Whether the OSRC is changing the OAAPI substantiation;

(d) If the OAAPI substantiation is changed, whether the changed conclusion is being changed to "unsubstantiated" or "inconclusive;" and

(e) A summary of the information used by the OSRC and its reasoning in reaching its decision.

(4) The OSRC shall operate as follows:

(a) The OSRC shall consider relevant documentary information contained in the OAAPI investigation file, investigative report and exhibits, and information provided by the person with substantiated abuse.

(b) The OSRC may not re-interview the victim; interview or meet with the person with substantiated abuse or CCA staff, with others associated with the person with substantiated abuse or CCA, or with others mentioned in the report; or conduct a field assessment of the allegation of abuse.

(c) All OSRC decisions shall be decided by majority vote of the three participating committee members, all of whom shall be present.

(d) The OSRC shall make a determination as to:

(A) Whether there is reasonable cause to believe that abuse occurred; and

(B) Whether there is reasonable cause to believe that the person with substantiated abuse or CCA is responsible for the abuse.

(e) The OSRC shall decide to either uphold the OAAPI substantiation, or change that conclusion to unsubstantiated or inconclusive.

(5) OSRC shall send the notice of OSRC decision to the person with substantiated abuse or CCA, the OAAPI investigator who conducted the investigation, applicable public agencies, other entities or individuals who received notice of the original substantiation, and the OAAPI Director.

(6) The Department shall provide the person with substantiated abuse a notice of rights to appeal the OSRC determination.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005 & OL 2016, Ch. 106
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0950
Exception to the Right to Request a Review and Providing Notice of Legal Proceeding

(1) If OAAPI has knowledge of a pending legal proceeding, the OSRC may not review the disposition until the legal proceeding is completed.

(2) If OAAPI has knowledge of a pending legal proceeding, OAAPI shall prepare and deliver a notice of legal proceeding within 30 calendar days after receipt of a request for review informing the person with substantiated abuse or CCA that the Department may not review the substantiation until the legal proceeding is completed and may not take further action on the request.

(3) If the completed legal proceeding results in a legal finding consistent with the OAAPI substantiation, the Department may not conduct a review. In that case, OAAPI shall provide a notice of legal finding to the person with substantiated abuse or CCA.

(4) If the completed legal proceeding results in a legal finding which is inconsistent with the OAAPI substantiation, the person with substantiated abuse or CCA may, at the conclusion of the legal proceeding, re-submit a request for review within 30 calendar days from the date of resolution of legal proceeding.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005 & OL 2016, Ch 106
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0955
Confidentiality

(1) The report and underlying investigatory documents are confidential and not available for public inspection. Except as provided in ORS 419B.035, names of witnesses and the alleged abuse victim are confidential unless the provisions of ORS 419B.035(1)(h) and (2)(a) apply. The

names and identifying information about a reporter are confidential and may not be disclosed. Investigatory documents, including portions of the abuse investigation report that contain "individually identifiable health information," as defined in ORS 192.519 and 45 CFR160.103, are confidential under HIPAA privacy rules, 45 CFR Part 160 and 164, and ORS 192.520 and 179.505 to 179.509. Disclosure of substance abuse treatment records are governed by 42 U.S.C. 290dd-2 and 42 CFR Part 2. The Department shall make otherwise confidential records available to individuals identified in ORS 419B.035(1), and may release records if permitted by ORS 419B.035(3) and other federal and state confidentiality laws.

(2) Except as provided in section (1) of this rule, the Department shall make the confidential information, including any photographs, available, if appropriate, to any law enforcement agency, to any public agency that licenses or certifies facilities, and to any public agency providing protective services for the child in care.

(3) Subject to ORS 419B.035(3), the Department may make the abuse investigation report or relevant materials, in redacted form, available to the CCA, any public agency that licenses or certifies the individuals working in a CCA, or to any person who was alleged to have abused the child in care under these rules. The Department may not disclose confidential information which is prohibited by state or federal law.

(4) Individuals or entities receiving confidential information pursuant to this rule shall maintain the confidentiality of the information and may not re-disclose the confidential information to unauthorized individuals or entities, if disclosure is prohibited by state or federal law.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 409.185, 409.225, 418.015, 418.205 – 418.327, 419B.005-050, 419B.035 & OL 2016, Ch 106
Hist.: DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0960
OIT Responsibilities Related to Notices and Reviews

(1) If a person or CCP asks to review Department records for the purpose of reviewing an OIT substantiation, state and federal confidentiality laws, including OAR 413-010-0000 to 413-010-0075 and 413-350-0000 to 413-350-0090, govern the inspection and copying of records.

(2) OIT must maintain records to demonstrate the following, when applicable:

(a) Whether the Department delivered a notice of OIT substantiation;

(b) Whether the notice of OIT substantiation was received by the addressee, as evidenced by a returned receipt documenting that the notice was received, refused, or not received; and

(c) The date a request for review was received by OIT.

(3) The OIT Director or designee must maintain a comprehensive record of completed OIT substantiation reviews.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0970
OSRC Review

(1) The OSRC shall conduct a review and issue a notice of OSRC decision within 60 calendar days from the date OIT receives a request for review.

(2) The OSRC shall operate as follows:

(a) The OSRC shall consider relevant documentary information contained in the OIT investigation file, investigative report and exhibits, and information provided by the person.

(b) The OSRC may not re-interview the victim; interview or meet with the person or CCP staff, with others associated with the person or CCP, or with others mentioned in the report; or conduct a field assessment of the allegation of child abuse or neglect.

(c) All OSRC decisions must be decided by majority vote of the three participating committee members, all of whom must be present.

(d) The OSRC shall make a determination as to:

(A) Whether there is reasonable cause to believe that child abuse or neglect occurred; and

(B) Whether there is reasonable cause to believe that the person or CCP is responsible for the child abuse or neglect.

(e) The OSRC shall decide to either uphold the OIT substantiation, or change that conclusion to not substantiated or inconclusive.

(3) Within 60 calendar days from the date the OSRC receives the request for review, the OSRC shall prepare and send to the requestor by certified mail or restricted delivery, with return receipt requested, a notice of OSRC decision that includes the following:

(a) Whether there is reasonable cause to believe that child abuse occurred;

(b) Whether there is reasonable cause to believe that the person or CCP was responsible for the child abuse;

(c) Whether the OSRC is changing the OIT substantiation;

(d) If the OIT substantiation is changed, whether the changed conclusion is being changed to "not substantiated" or "inconclusive;" and

(e) A summary of the information used by the OSRC and its reasoning in reaching its decision.

(4) OSRC shall send the notice of OSRC decision to the person or CCP, CAF, the OIT investigator who conducted the investigation, applicable public agencies, other entities or individuals who received notice of the original substantiation, and the OIT Director.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 8-2008, f. 8-29-08, cert. ef. 9-1-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; Suspended by DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

407-045-0980
Retaliation Prohibited

(1) No individual, including a child in care who reports suspected abuse, shall be subject to retaliatory action by a CCA.

(2) Any individual who makes a report of suspected abuse of a child in care to the Governor, the Department of Justice, or the Department in good faith and who has reasonable grounds for the making of the report shall have immunity:

(a) From any liability, civil or criminal, that might otherwise be incurred or imposed with respect to the making or content of such report;

(b) From disciplinary action taken by the individual's employer; and

(c) With respect to participating in any judicial proceeding resulting from or involving the report.

(3) An individual making a report under this section may include references to otherwise confidential information for the sole purpose of making the report, and any such disclosure shall be protected from further disclosure to other individuals or entities for any other purpose not related to the making of the report.

Stat. Auth.: ORS 409.050 & 418.005
Stats. Implemented: ORS 418.005 & OL 2016, Ch 106
Hist.: DHSD 12-2007(Temp), f. & cert. ef.12-3-07 thru 5-30-08; DHSD 4-2008, f. & cert. ef. 5-30-08; DHSD 5-2010, f. 6-30-10, cert. ef. 7-1-10; DHSD 7-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

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

Rule Caption: APD - Home and Community-Based Services and Settings for Adult Foster Homes
Adm. Order No.: APD 9-2016
Filed with Sec. of State: 6-27-2016
Certified to be Effective: 6-28-16
Notice Publication Date: 5-1-2016
Rules Amended: 411-050-0602, 411-050-0610, 411-050-0615, 411-050-0625, 411-050-0630, 411-050-0632, 411-050-0635, 411-050-0640, 411-050-0642, 411-050-0645, 411-050-0650, 411-050-0655, 411-050-0660, 411-050-0662, 411-050-0665, 411-050-0670, 411-050-0685
Rules Repealed: 411-050-0602(T), 411-050-0615(T), 411-050-0630(T), 411-050-0632(T), 411-050-0635(T), 411-050-0642(T), 411-050-0645(T), 411-050-0650(T), 411-050-0655(T), 411-050-0662(T), 411-050-0670(T), 411-050-0685(T)
Subject: The Department of Human Services (Department) is permanently amending the rules in OAR chapter 411, division 050 to make permanent temporary changes that became effective on January 1, 2016 for adult foster homes where care is provided to older adults or adults with physical disabilities to align the rules with the newly adopted rules in 411-004.

The Department is also updating the rules to improve and streamline processes and to make changes to enhance the safety and welfare of adult foster home residents and licensees. The Department updated the rules to ensure the rules were using current Department

terminology and to perform minor grammar, punctuation, formatting, and housekeeping changes.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-050-0602
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 050:

(1) "AAA" means an Area Agency on Aging, which is an established public agency within a planning and service area designated under Section 305 of the Older Americans Act that has responsibility for local administration of programs within the Department of Human Services. For the purpose of these rules, Type B AAAs contract with the Department to perform specific activities in relation to licensing adult foster homes, including processing applications, conducting inspections and investigations, issuing licenses, and making recommendations to the Department regarding adult foster home license denial, revocation, suspension, non-renewal, and civil penalties.

(2) "Abuse" means "abuse" as defined in OAR 411-020-0002 (Adult Protective Services).

(3) "Activities of Daily Living (ADL)" mean the personal, functional activities defined in OAR 411-015-0006 (Long-term Care Service Priorities for Individuals Served) required by an individual for continued well-being, which are essential for health and safety.

(4) "Adult Foster Home (AFH)" means any family home or other facility where residential care is provided in a home-like environment for compensation to five or fewer adults who are not related to the licensee, resident manager, or floating resident manager, by blood, marriage, or adoption and who are 65 years of age or older or an adult with a physical disability. For the purpose of these rules, "adult foster home" does not include any house, institution, hotel, or other similar living situation that supplies room or board only, if no resident thereof requires any element of care. "Facility" and "Home" are synonymous with "Adult Foster Home".

(5) "Advance Directive" or "Advance Directive for Health Care" means the legal document signed by a resident that provides health care instructions in the event the resident is no longer able to give directions regarding his or her wishes. The directive gives the resident the means to control his or her own health care in any circumstance. "Advance Directive for Health Care" does not include Physician Orders for Life-Sustaining Treatment (POLST).

(6) "Applicant" means a person who completes an application for an adult foster home license or who completes an application to become a resident manager, floating resident manager, or shift caregiver. "Applicant" is synonymous with "Co-applicant".

(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) "Back-Up Provider" means a licensee, approved resident manager, or approved floating resident manager who does not live in the home, who has agreed to oversee the operation of an adult foster home, of the same license classification or level, in the event of an emergency.

(9) "Behavioral Interventions" mean those interventions that modify a resident's behavior or a resident's environment.

(10) "Board of Nursing Rules" means the standards for Registered Nurse Teaching and Delegation to Unlicensed Persons according to the statutes and rules of the Oregon State Board of Nursing, ORS 678.010 to 678.445 and OAR chapter 851, division 047.

(11) "Care" means the provision of assistance with activities of daily living to promote a resident's maximum independence and enhance the resident's quality of life. "Care" includes, but is not limited to, assistance with bathing, dressing, grooming, eating, money management, recreation, and medication management excluding assistance with self-medication.

(12) "Caregiver" means any person responsible for providing care and services to residents, including the licensee, resident manager, floating resident manager, shift caregivers, and any temporary, substitute, or supplemental staff, or other person designated to provide care and services to residents.

(13) "Care Plan" means a licensee's written description of a resident's needs, preferences, and capabilities, including by whom, when, and how often care and services are to be provided.

(14) "Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the United States Department of Health and Human Services responsible for the administration of Medicaid and the Health Insurance Portability and Accountability Act (HIPAA).

(15) "Classification" means a designation of license assigned to a licensee based on the qualifications of the licensee, resident manager, floating resident manager, and shift caregivers, as applicable.

(16) "Co-Applicant" is synonymous with "Applicant" as defined in this rule.

(17) "Code of Federal Regulations" or "CFR" means the codification of the rules and regulations published in the Federal Register, and produced by the executive departments and agencies of the federal government of the United States.

(18) "Co-Licensee" is synonymous with "Licensee" as defined in this rule.

(19) "Compensation" means monetary or in-kind payments by or on behalf of a resident to a licensee in exchange for room, board, care, and services. "Compensation" does not include the voluntary sharing of expenses between or among roommates.

(20) "Complaint" means an allegation of abuse, a violation of these rules, or an expression of dissatisfaction relating to a resident or the condition of an adult foster home.

(21) "Condition" means a provision attached to a new or existing license that limits or restricts the scope of the license or imposes additional requirements on the licensee.

(22) "Consumer" means an individual eligible for Medicaid services for whom case management services are provided by the Department.

(23) "Criminal Records and Abuse Check Rules" refers to OAR 407-007-0200 to 407-007-0370.

(24) "Day Care" means care, assistance, and supervision of an individual who is older, as defined in these rules, who does not stay overnight.

(25) "Delegation" means the process where a registered nurse teaches and supervises a skilled nursing task.

(26) "Department" means the Department of Human Services.

(27) "Designated Representative" means:

(a) Any adult, such as a parent, family member, guardian, advocate, or other person who is:

(A) Chosen by the individual, or as applicable the legal representative;

(B) Not a paid provider for the individual; and

(C) Authorized by the individual, or as applicable the legal representative, to serve as the representative of the individual, or as applicable the legal representative, in connection with the provision of funded supports.

(b) The power to act as a designated representative is valid until the individual modifies the authorization or notifies the agency that the designated representative is no longer authorized to act on his or her behalf.

(c) An individual, or as applicable the legal representative, is not required to appoint a designated representative.

(28) "Director" means the Director of the Department of Human Services or that person's designee.

(29) "Disability" means a physical, cognitive, or emotional impairment, which for an individual, constitutes or results in a functional limitation in one or more activities of daily living.

(30) "Disaster" means a sudden emergency occurrence beyond the control of the licensee, whether natural, technological, or man-made that renders the licensee unable to operate the facility or renders the facility uninhabitable on a temporary, extended, or permanent basis.

(31) "Emergency Preparedness Plan" means a written procedure that identifies a facility's response to an emergency or disaster for the purpose of minimizing loss of life, mitigating trauma, and to the extent possible, maintaining services for residents, and preventing or reducing property loss.

(32) "Entity" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation.

(33) "Exclusion Lists" mean the following federal lists that exclude listed individuals from receiving federal awards, not limited to Medicaid and Medicare programs:

(a) The U.S. Office of Inspector General's Exclusion List at www.exclusions.oig.hhs.gov/; and

(b) The U.S. General Services Administration's System for Award Management Exclusion List at www.sam.gov.

(34) "Exempt Area" means a county where there is a county agency that provides similar programs for licensing and inspection of adult foster homes that the Director finds are equal or superior to the requirements of ORS 443.705 to 443.825 and that the Director has exempted from the license, inspection, and fee provisions of ORS 443.705 to 443.825.

"Exempt area" county licensing rules require review and approval by the Director before implementation.

(35) "Facility" is synonymous with "Adult Foster Home" as defined in this rule.

(36) "Family Member" means spouses in a legally recognized marriage or domestic partnership, natural parent, child, sibling, adopted child, adoptive parent, adoptive sibling, 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.

(37) "Final Point of Safety" means a designated assembly area located on a public sidewalk or street not less than 50 feet away from an adult foster home where occupants of the home evacuate to in the event of an emergency.

(38) "Floating Resident Manager" means an employee of the licensee, approved by the local licensing authority, who under the direction of the licensee, is directly responsible for the care of residents in one or more adult foster homes owned by that licensee. A "floating resident manager" is not required to live in any one adult foster home owned by his or her employer, except on a temporary basis, as directed by the licensee, when the regularly scheduled caregiver is unavailable.

(39) "Home" means the physical structure where residents live. "Home" is synonymous with "Adult Foster Home" as defined in this rule.

(40) "Home and Community-Based Services" or "HCBS" means Home and Community-Based Services as defined in OAR chapter 411, division 004.

(41) "Home and Community-Based Settings" or "HCB Settings" means a physical location meeting the qualities of OAR 411-004-0020 where an individual receives Home and Community-Based Services.

(42) "Home-like" means an environment that promotes the dignity, security, and comfort of residents through the provision of personalized care and services, and encourages independence, choice, and decision-making by the residents.

(43) "House Policies" or the "Home's Policies" means the written and posted statements addressing house activities in an adult foster home identified in the Residency Agreement.

(44) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity.

(45) "Individual" means an adult who is at least 65 years of age, or is an adult with physical disabilities who is receiving Home and Community-Based Services. For Home and Community-Based Settings, "Resident" includes individuals receiving day care services.

(46) "Individually-Based Limitation" or "Limitation" means:

(a) Any limitation to the following areas, as described in OAR 411-004-0020(2)(d) to (2)(j), which includes the right to:

(A) The freedom and support to access food at any time;

(B) Have visitors of the resident's choosing at any time;

(C) Have a lockable door in the resident's bedroom, which may be locked by the individual;

(D) Choose a roommate when sharing a bedroom;

(E) Furnish and decorate the resident's bedroom according to the Residency Agreement;

(F) The freedom and support to control the resident's schedule and activities;

(G) Privacy in the resident's bedroom;

(b) A limitation must be based on a specific assessed need, and may only be implemented with the informed consent of the resident or the resident's legal representative.

(47) "Informed Consent" means:

(a) Options, risks, and benefits have been explained to the individual and, as applicable the legal representative of the individual, in a manner that the individual, and as applicable, the representative, comprehends; and

(b) The individual or, as applicable, the legal representative of the individual, consents to a person-centered service plan of action, including any individually-based limitations to the rules, before implementation of the initial or updated person-centered service plan or any individually-based limitation.

(48) "Initial Point of Safety" means a designated area that has unobstructed direct access to a public sidewalk or street located not less than 25 feet away from an adult foster home where occupants of the home evacuate to in the event of an emergency and for the purpose of conducting evacuation drills.

(49) "Investigative Authority" means the Office of Adult Abuse Prevention and Investigation, local Department offices, and Area Agencies on Aging that contract with the Department to provide adult protective services to adults who are older or adults with physical, mental, or developmental disabilities.

(50) "Legal Representative" means a person who has the legal authority to act for an individual. The legal representative only has authority to act within the scope and limits of his or her authority as designated by the court or other agreement.

(a) Legal representatives acting outside of his or her authority or scope must meet the definition of designated representative.

(b) For an individual 18 years of age or older, a guardian appointed by a court order or an agent legally designated as the health care representative, where the court order or the written designation provide authority for the appointed or designated person to make the decisions indicated where the term "legal representative" is used in this rule.

(51) "Level" means the designation of ventilator-assisted care assigned to an adult foster home license based on the qualifications of the licensee, resident manager, floating resident manager, and shift caregivers, as applicable.

(52) "Licensed Health Care Professional" means a person who possesses a professional medical license that is valid in Oregon. Examples include, but are not limited to, a registered nurse (RN), nurse practitioner (NP), licensed practical nurse (LPN), medical doctor (MD), osteopathic physician (DO), respiratory therapist (RT), physical therapist (PT), physician assistant (PA), or occupational therapist (OT).

(53) "Licensee" means the person who was issued a license, whose name is on the license, and who is responsible for the operation of an adult foster home. The "licensee" of the adult foster home does not include the owner or lessor of the building where the adult foster home is situated unless the owner or lessor of the building is also the operator.

(54) "Limited Adult Foster Home" means a home that provides care and services for compensation to a specific individual who is unrelated to the licensee but with whom the licensee has an established relationship of no less than one year.

(55) "Liquid Resource" means cash or those assets that may readily be converted to cash, such as a life insurance policy that has a cash value, stock certificates, or a guaranteed line of credit from a financial institution.

(56) "Local Licensing Authority" means the local Department offices and Area Agencies on Aging that contract with the Department to perform specific functions of the adult foster home licensing process.

(57) "Nursing Care" means the practice of nursing by a licensed nurse, including tasks and functions relating to the provision of "nursing care" that are taught or delegated under specified conditions by a registered nurse to a person other than licensed nursing personnel, as governed by ORS chapter 678 and rules adopted by the Oregon State Board of Nursing in OAR chapter 851.

(58) "Occupant" means any person residing in or using the facilities of an adult foster home, including residents, licensees, resident manager, friends or family members, day care individuals, and room and board tenants. A floating resident manager who resides in an adult foster home on a temporary basis is considered an "occupant".

(59) "Older" means any person at least 65 years of age.

(60) "Ombudsman" means the Oregon Long-Term Care Ombudsman or a designee appointed by the Long-Term Care Ombudsman to serve as a representative of the Ombudsman Program in order to investigate and resolve complaints on behalf of adult foster home residents.

(61) "Operator" is synonymous with "Licensee" as defined in this rule.

(62) "Ownership Interest" means the possession of equity in the capital, stock, or profits of an adult foster home. Persons with an ownership or control interest mean a person or corporation that:

(a) Has an "ownership interest" totaling five percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to five percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity;

(d) Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

(63) "Person-Centered Service Plan" as defined in OAR chapter 411, division 004.

(a) FOR INDIVIDUALS RECEIVING MEDICAID. The person-centered service plan coordinator completes the person-centered service plan.

(b) FOR NON-MEDICAID INDIVIDUALS. The person-centered service plan may be completed by the resident, and as applicable, the representative of the individual, and others as chosen by the individual. The licensee may assist non-Medicaid individuals in developing person-centered service plans when no alternative resources are available. The elements of the individual's person-centered service plan may be incorporated into the resident's care plan.

(64) "Person-Centered Service Plan Coordinator" means case managers, services coordinators, personal agents, and other people designated by DHS or OHA to provide case management services or person-centered service planning for and with individuals.

(65) "Physical Restraint" means any manual method or physical or mechanical device, material, or equipment attached to, or adjacent to, a resident's body that the resident may not easily remove and that restricts freedom of movement or normal access to his or her body. Physical restraints include, but are not limited to, wrist or leg restraints, soft ties or vests, hand mitts, wheelchair safety bars, lap trays, and any chair that prevents rising (such as a Geri-chair). Side rails (bed rails) are considered restraints when they are used to prevent a resident from getting out of a bed. The side rail is not considered a restraint when a resident requests a side rail for the purpose of assistance with turning.

(66) "Prescribing Practitioner" means a physician, nurse practitioner, physician assistant, chiropractor, dentist, ophthalmologist, or other health-care practitioner with prescribing authority.

(67) "Primary Caregiver" means a qualified licensee or resident manager, who lives in the home, personally provides care and services, and ensures the health and safety of residents a minimum of five consecutive days per week. More than one person who meets this criterion may be considered a "primary caregiver" as specified below:

(a) Co-licensees working three and four consecutive days and nights per week;

(b) Two approved resident managers working three and four consecutive days and nights per week; or

(c) A licensee and an approved resident manager working three and four consecutive days and nights per week.

(68) "P.R.N. (pro re nata)" means those medications and treatments that have been ordered by a qualified practitioner to be administered as needed.

(69) "Provider" means any person operating an adult foster home (i.e., licensee, resident manager, floating resident manager, or shift caregiver). "Provider" does not include substitute caregivers or the owner or lessor of the building where the adult foster home is situated unless the owner or lessor is also the operator of the adult foster home.

(70) "Provisional License" means a 60-day license issued in an emergency situation when a licensed provider is no longer overseeing the operation of an adult foster home. A provisional license is issued to a qualified person who meets the standards of OAR 411-050-0625 and OAR 411-050-0630, except for completing the training and testing requirements. (See OAR 411-050-0635).

(71) "Psychoactive Medications" mean various medications used to alter mood, anxiety, behavior, or cognitive processes. For the purpose of these rules, "psychoactive medications" include, but are not limited to, antipsychotics, sedatives, hypnotics, and antianxiety medications.

(72) "Qualified Entity Initiator (QEI)" has the meaning set forth in OAR 407-007-0210 (Criminal Records and Abuse Checks for Providers).

(73) "Relative" means those persons identified as family members as defined in this rule.

(74) "Representative" means "Designated Representative" and "Legal Representative" as defined in these rules, unless otherwise stated.

(75) "Reside" means for a person to live in an adult foster home for a permanent or extended period of time. For the purpose of a background check, a person is considered to "reside" in a home if the person's visit is four weeks or greater.

(76) "Residency Agreement" or "Agreement" means the written and legally enforceable agreement between an adult foster home licensee and an individual receiving Home and Community Based Services (HCBS), or representative of the individual, in a provider owned, controlled, or operated setting. The Residency Agreement identifies the policies of the home, services to be provided, and the rights and responsibilities of the individual, and the licensee. The Residency Agreement provides the individual protection from eviction substantially equivalent to landlord-tenant laws.

(77) "Resident" means an adult who is at least 65 years of age, or an adult with a physical disability who is receiving room and board and care and services in an adult foster home on a 24-hour day basis in exchange for compensation. For the purposes of this definition, Resident includes individuals receiving day care services. (See OAR 411-050-0615).

(78) "Resident Manager" means an employee of the licensee, approved by the local licensing authority, who lives in the adult foster home, and is directly responsible for the care of the residents.

(79) "Resident Rights" or "Rights" means civil, legal, or human rights, including, but not limited to, those rights listed in the Adult Foster Home Residents' Bill of Rights. (See ORS 443.739 and OAR 411-050-0655).

(80) "Residential Care" means the provision of care on a 24-hour day basis.

(81) "Room and Board" means receiving compensation for the provision of meals, a place to sleep, laundry, and housekeeping to adults who are older or adults with physical disabilities and who do not need assistance with activities of daily living. Room and board facilities for two or more persons are required to register with the Department under the rules in OAR chapter 411, division 068, unless registered with the local authority having jurisdiction. Adult foster homes with room and board tenants are not subject to OAR chapter 411, division 068.

(82) "Screening" means the evaluation process used to identify an individual's ability to perform activities of daily living and address health and safety concerns.

(83) "Self-Administration of Medication" means the act of a resident placing a medication in or on his or her own body. The resident identifies the medication, the time and manner of administration, and places the medication internally or externally on his or her own body without assistance.

(84) "Self-Preservation" in relation to fire and life safety means the ability of a resident to respond to an alarm without additional cues and reach a point of safety without assistance.

(85) "Services" mean activities that help the residents develop skills to increase or maintain the resident's level of functioning or assist the residents to perform personal care, activities of daily living, or individual social activities.

(86) "Shift Caregivers" mean caregivers who, by written variance of the local licensing authority, are responsible for providing care for regularly scheduled periods of time, such as 8 or 12 hours per day, in homes where there is no licensee or resident manager living in the home.

(87) "Subject Individual" means "subject individual" as defined in OAR 407-007-0210 and means any person 16 years of age or older, including:

(a) All licensed adult foster home providers and provider applicants;

(b) All persons intending to work in, or currently working in an adult foster home, including, but not limited to, caregivers and individuals in training;

(c) Volunteers on the home's premises who provide services for, or who have unsupervised access to any resident, or any resident's funds, belongings, or confidential information; and

(d) Occupants, excluding residents, residing in or on the premises of a proposed or currently licensed adult foster home, including:

(A) Household members;

(B) Room and board tenants; and

(C) Persons staying in the home for a period of four weeks or more.

(e) "Subject Individual" does not apply to:

(A) Persons under 16 years of age;

(B) Residents of the adult foster home or the resident's visitors;

(C) Persons who live or work in or on the adult foster home premises who do not:

(i) Have regular access to the home for meals; or

(ii) Have regular use of the adult foster home's appliances or facilities; or

(iii) Have unsupervised access to the residents or the residents' personal property.

(D) A person providing services to the residents who is employed by a private business not regulated by the Department.

(88) "Substantial Compliance" means a level of compliance with these rules where any deficiencies pose no greater risk to resident health or safety than the potential for causing minor harm.

(89) "Substitute Caregiver" means any person other than the licensee, resident manager, floating resident manager, or shift caregiver who provides care and services in an adult foster home under the jurisdiction of the Department.

(90) "Tenant" means any individual who is residing in an adult foster home who receives services, such as meal preparation, laundry, and housekeeping.

(91) "Tenancy Agreement" means a written and legally enforceable agreement between an adult foster home licensee and an adult who is older or an adult with physical disabilities who resides in the home and does not require assistance with any activity of daily living. The agreement specifies the terms and conditions of a room and board residency in the home.

(92) "These Rules" mean the rules in OAR chapter 411, division 050.

(93) "Variance" means an exception from a regulation or provision of these rules in accordance with OAR 411-050-0642.

(94) "Ventilator-Assisted Care" means the provision of mechanical assistance to replace spontaneous breathing. Devices used include, but are not limited to, mechanical ventilators, manual ventilators, and positive airway pressure ventilators.

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

Stats. Implemented: ORS 106.010, 443.001-004, 443.705-825, 443.875, 443.991

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0400, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 50-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0610

Initial License Application and Fees

(1) The applicant must complete the Department's application form for the specific type of license requested and submit the application form to the local licensing authority with the non-refundable fee.

(a) The application is not complete until all of the required information is submitted to the local licensing authority. Incomplete applications are void after 60 calendar days from the date the local licensing authority receives the application form and non-refundable fee, and the Department may deny the application if not withdrawn.

(b) Failure to provide accurate information may result in the denial of the application.

(2) A separate application is required for each location where an adult foster home is to be operated.

(3) The license application must include:

(a) Complete contact information for the applicant including:

(A) A mailing address if different from the proposed adult foster home; and

(B) A business address for electronic mail.

(b) Verification of attendance at a Department-approved orientation program conducted by the local licensing authority responsible for the licensing of the proposed adult foster home and successful completion of the Department's Ensuring Quality Care Course and examination. (See OAR 411-050-0625);

(c) The maximum resident capacity requested;

(d) Identification of:

(A) Any relatives needing care;

(B) The maximum number of any room and board tenants;

(C) The maximum number of day care individuals; and

(D) The names of any other occupants in the home.

(e) The classification being requested with information and supporting documentation regarding qualifications, relevant work experience, and training of staff as required by the Department. To request a Class 3 license, the license application must include:

(A) Proof of at least three years of full-time experience providing direct care to adults who are older or adults with physical disabilities and who required full assistance in four or more of activities of daily living; and

(B) Current contact information from at least two licensed health care professionals who have direct knowledge of the applicant's abilities and past experience as a caregiver; or

(C) A copy of the applicant's current license as a health care professional in Oregon, if applicable.

(f) A Health History and Physician or Nurse Practitioner's Statement (form SDS 903) regarding the applicant's ability to provide care;

(g) FINANCIAL INFORMATION. A completed Financial Information Sheet (form SDS 448A).

(A) An applicant must have the financial ability and maintain sufficient liquid resources to pay the operating costs of an adult foster home for at least two months without solely relying on potential resident income.

(B) Documentation of two months of liquid resources must include:

(i) The Department's current Verification of Financial Resources form (SDS 0448F) completed and stamped or notarized by the applicant's financial institution; or

(ii) Documentation on letterhead of the applicant's financial institution, which includes:

(I) The last four digits of the applicant's account number;

(II) The name of the account holder and, if the account is not in the applicant's name, verification the applicant has access to the account's funds;

(III) The highest and lowest balances for each of the most recent three full months; and

(IV) The number of any non-sufficient fund (NSF) payments in each of the last three full months, if any; or

(iii) Demonstration of cash on hand equal to a minimum of two months of operating expenses.

(C) If an applicant uses income from another adult foster home to document possession of at least two months of operating expenses, the applicant must demonstrate the financial ability and maintain sufficient liquid resources to pay the operating costs of each home for at least two months without solely relying on potential resident income.

(h) If the home is leased or rented, a copy of the completed lease or rental agreement. The agreement must be a standard lease or rental agreement for residential use and include the following:

(A) The owner and landlord's name;

(B) Verification that the rent is a flat rate; and

(C) The signatures of the landlord and applicant and the date signed;

(i) If the applicant is purchasing or owns the home, verification of purchase or ownership;

(j) Documentation of the initiation of a background check or a copy of an approved background check for each subject individual as defined in OAR 411-050-0602;

(k) A current and accurate floor plan that indicates:

(A) The size of rooms;

(B) Which bedrooms are to be used by residents, the licensee, caregivers, for day care, and room and board tenants, as applicable;

(C) The location of all the exits on each level of the home, including emergency exits such as windows;

(D) The location of any wheelchair ramps;

(E) The location of all fire extinguishers, smoke alarms, and carbon monoxide alarms;

(F) The planned evacuation routes, initial point of safety, and final point of safety; and

(G) Any designated smoking areas in or on the adult foster home premises.

(l) If requesting a license to operate more than one home, a plan covering administrative responsibilities and staffing qualifications for each home;

(m) A $20 per bed non-refundable fee for each non-relative resident;

(n) Three personal references for the applicant who are not family members as defined in OAR 411-050-0602. Current or potential licensees and co-workers of current or potential licensees are not eligible as personal references;

(o) If the applicant intends to use a resident manager, floating resident manager, or shift caregivers, the Department's supplemental application (form SDS 448B) completed by the applicant, as appropriate;

(p) Written information describing the operational plan for the adult foster home including:

(A) The use of substitute caregivers and other staff;

(B) A plan of coverage for the absence of the primary caregiver; and

(C) The name of a qualified back-up provider, approved resident manager, or approved floating resident manager who does not live in the home but has been oriented to the home. The applicant must also submit a signed agreement with the listed back-up provider and maintain a copy in the facility records.

(q) Copies of the home's Residency Agreements according to OAR 411-050-0615(2).

(4) After receipt of the completed application materials including the non-refundable fee, the local licensing authority must investigate the information submitted including pertinent information received from outside sources, inspect the home, and conduct a personal interview with the applicant.

(5) The Department shall deny the issuance of a license if cited violations from the home inspection are not corrected within the time frames specified by the local licensing authority.

(6) The applicant may withdraw his or her application at any time during the application process by written notification to the local licensing authority.

(7) An applicant whose license has been revoked, non-renewed, voluntarily surrendered during a revocation or non-renewal process, or whose application for licensure has been denied, shall not be granted a new license by the local licensing authority for a period of not less than one year from the date the action was final, or for a longer period if specified in the final order.

(8) All moneys collected under ORS 443.725 to 443.825 are paid to the Quality Care Fund.

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

Stats. Implemented: ORS 443.001-004, 443.705-825, 443.875, 443.991

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0410, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0615

Provider Enrollment Agreements, Residency Agreements, and Refunds

(1) MEDICAID PROVIDER ENROLLMENT AGREEMENT.

(a) An applicant or licensee who intends to care for residents who are or become eligible for Medicaid services must enter into a Medicaid Provider Enrollment Agreement with the Department, follow Department rules, and abide by the terms of the Medicaid Provider Enrollment Agreement. The local licensing authority shall determine that the applicant, licensee, and any owner or officer of the corporation, as applicable, is not listed on either of the Exclusion Lists before approval of a Medicaid Provider Enrollment Agreement.

(b) An approved Medicaid Provider Enrollment Agreement does not guarantee the placement of individuals eligible for Medicaid services in the adult foster home.

(c) An approved Medicaid Provider Enrollment Agreement is valid for the length of the license unless earlier terminated by the licensee or the Department. A Medicaid Provider Enrollment Agreement must be completed, submitted, approved, and renewed with each licensing cycle.

(d) The rate of compensation established by the Department is considered payment in full. The licensee may not request or accept additional funds or in-kind payment from any source.

(e) An individual eligible for Medicaid services may not be admitted into an adult foster home unless and until:

(A) The Department has approved a Medicaid Provider Enrollment Agreement. The Department shall not issue a Medicaid payment to a licensee without a current license and an approved Medicaid Provider Enrollment Agreement in place;

(B) The individual eligible for Medicaid services has been screened according to OAR 411-050-0655; and

(C) The Department has authorized the placement. The authorization must be clearly documented in the resident's record with other required admission materials. (See OAR 411-050-0655).

(f) The Department shall not make payment for the date a resident moves from the home, or for any time period thereafter.

(g) The licensee must enter into a written agreement with a resident who receives Medicaid services if the licensee charges for storage of belongings that remain in the adult foster home for more than 15 calendar days after the resident has left the home.

(A) The written agreement must be consistent with the licensee's policy with private-pay residents and entered into at the time of the resident's admission or at the time the resident becomes eligible for Medicaid services.

(B) The licensee must give written notice to the resident and the resident's family or other representatives 30 calendar days before any increases, additions, or other modifications to the charges for storage.

(h) A licensee who elects to provide care for individuals eligible for Medicaid services is not required to admit more than one resident eligible for Medicaid services. However, if the licensee has an approved Medicaid Provider Enrollment Agreement, private-pay residents who become eligible for Medicaid services may not be asked to leave solely on the basis of Medicaid eligibility.

(i) The licensee or the Department may terminate a Medicaid Provider Enrollment Agreement according to the terms of the Medicaid Provider Enrollment Agreement.

(j) The Department may terminate a Medicaid Provider Enrollment Agreement under the following circumstances:

(A) The licensee fails to maintain substantial compliance with all related federal, state, and local laws, ordinances, and regulations; or

(B) The license to operate the adult foster home has been voluntarily surrendered, revoked, or non-renewed.

(k) The Department must terminate a Medicaid Provider Enrollment Agreement under the following circumstances:

(A) The licensee fails to permit access by the Department, the local licensing authority, or the Centers for Medicare and Medicaid Services to any adult foster home licensed to and operated by the licensee;

(B) The licensee submits false or inaccurate information;

(C) Any person with five percent or greater direct or indirect ownership interest in the adult foster home did not submit timely and accurate information on the Medicaid Provider Enrollment Agreement form or fails to submit fingerprints if required under the criminal records and abuse check rules in OAR 407-007-0200 to 407-007-0370;

(D) Any person with five percent or greater direct or indirect ownership interest in the adult foster home has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI programs in the last 10 years; or

(E) Any person with an ownership or control interest, or who is an agent or managing employee of the adult foster home, fails to submit timely and accurate information on the Medicaid Provider Enrollment Agreement form.

(l) If the licensee submits notice of termination of the Medicaid Provider Enrollment Agreement, the licensee must comply with the following requirements:

(A) Simultaneously issue the Department's Notice of Involuntary Move or Transfer of Resident form (SDS 901) to each resident eligible for Medicaid services in the licensee's adult foster home (See OAR 411-050-0645).

(B) Update Residency Agreement and submit to the local licensing authority for review.

(C) Obtain signatures of all current residents, or the resident's representative on the updated Residency Agreement following the local licensing authority's review.

(m) If either the licensee or the Department terminates a Medicaid Provider Enrollment Agreement, a new Medicaid Provider Enrollment Agreement shall not be approved by the local licensing authority for a period of not less than 180 days from the date the licensee or the Department terminated the Medicaid Provider Enrollment Agreement.

(n) DEATH OF RESIDENT ELIGIBLE FOR MEDICAID SERVICES WITH NO SURVIVING SPOUSE. The licensee must forward all personal incidental funds (PIF) to the Estate Administration Unit, P. O. Box 14021, Salem, Oregon 97309-5024, within 10 business days of the death of a resident eligible for Medicaid services with no surviving spouse. (See Limits on Estate Claims, OAR 461-135-0835).

(2) RESIDENCY AGREEMENT. A licensee must enter into a written Agreement with all residents or the residents' representatives, which details the care and services to be provided, and the rate to be charged. The written Agreement must be signed by all parties before the admission of the resident. A copy of the Agreement is subject to review for compliance with these rules by the local licensing authority before licensure and before the implementation of any changes to the Agreement.

(a) The Agreement must include, but not be limited to:

(A) Services to be provided and the rate to be charged. For individuals receiving Medicaid, the Residency Agreement may state the rate will be "as authorized by the Department". A payment range may not be used unless the Agreement plainly states when an increase in rate may be expected based on a resident's increased care or service needs.

(B) Conditions under which the rates may be changed.

(C) The home's refund policy in instances of a resident's hospitalization, death, transfer to a nursing facility or other care facility, and voluntary or involuntary move. The refund policy must be in compliance with section (3) of this rule.

(D) A statement indicating that the resident is not liable for damages considered normal wear and tear on the adult foster home and the adult foster home's contents.

(b) The Agreement must disclose:

(A) The home's policies on moves, including:

(i) Voluntary moves and whether or not the licensee requires written notification of a non-Medicaid resident's intent to not return.

(ii) Involuntary moves and the resident's rights according to OAR 411-050-0445(11) and (12).

(B) Any charges for storage of belongings that remain in the adult foster home for more than 15 calendar days after the resident has left the home.

(C) Any policies the adult foster home may have on the use of alcohol, tobacco, intercoms, and monitors.

(D) The home's smoking policies in compliance with OAR 411-050-0650.

(E) The home's policy regarding animals. Restrictions may not apply to animals that provide assistance or perform tasks for the benefit of a person with a disability. Such animals are often referred to as service animals, assistance animals, support animals, therapy animals, companion animals, or emotional support animals.

(F) The home's policy regarding the presence and use of legal medical and recreational marijuana on the premises.

(G) The home's schedule of meal times with no more than a 14-hour span between the evening meal and the following morning's meal (See OAR 411-050-0645).

(H) Whether the home serves individuals eligible for Medicaid services.

(I) The home's policy regarding refunds for residents eligible for Medicaid services, including pro-rating partial months and if the room and board is refundable.

(J) A clear and precise statement of any limitation to the implementation of Advance Directives on the basis of conscience. This rule does not apply to medical professional or hospice orders for administration of medications. The statement must include:

(i) A description of conscientious objections as they apply to all occupants of the adult foster home;

(ii) The legal authority permitting such objections under ORS 127.505 to 127.660; and

(iii) Description of the range of medical conditions or procedures affected by the conscientious objection.

(c) The Agreement must:

(A) Not conflict with the Resident's Rights, the family atmosphere of the home, or any of these rules; and

(B) Be reviewed and approved by the local licensing authority before the issuance of a license, and before implementing any changes.

(d) Providers initially licensed before January 1, 2016 have until September 1, 2018 to fully comply with this rule. The Agreement must include the freedoms authorized by 42 CFR 441.301(c)(4) & 42 CFR 441.530(a)(1), which must not be limited without the informed, written consent of the resident or the resident's representative, and approved by the person-centered service plan coordinator, which includes the right to:

(A) The freedom and support to access food at any time;

(B) To have visitors of the resident's choosing at any time;

(C) Have a lockable door in the resident's bedroom, which may be locked by the resident;

(D) Choose a roommate when sharing a bedroom;

(E) Furnish and decorate the resident's bedroom according to the Residency Agreement;

(F) The freedom and support to control the resident's schedule and activities;

(G) Privacy in the resident's bedroom.

(e) The licensee may not charge or ask for application fees or non-refundable deposits. Fees to hold a bed are permissible.

(f) The licensee must give a copy of the signed Agreement to the resident or the resident's representative and must retain the original signed Agreement and any amendments on the premises available for review.

(g) The licensee may not include any illegal or unenforceable provision in an Agreement with a resident and may not ask or require a resident to waive any of the resident's rights or licensee's liability for negligence.

(h) The licensee must give written notice to a non-Medicaid resident and the resident's family or other representatives 30 calendar days before any general rate increases, additions, or other modifications of the rates. The licensee is not required to give 30 day written notice if the rate change is due to the resident's increased care or service needs and the agreed upon rate schedule in the resident's Agreement has specified charges for those changes.

(3) REFUNDS FOR NON-MEDICAID RESIDENTS.

(a) If a resident dies, the licensee may not retain or require payment for more than 15 calendar days after the date of the resident's death, or the time specified in the licensee's Agreement, whichever is less.

(b) If a resident leaves an adult foster home for medical reasons and the resident or the resident's representative indicates the resident's intent to not return, the licensee may not retain or require payment for more than 15 calendar days after the date the licensee receives notification from the resident, the resident's representative, or the time specified in the licensee's Agreement, whichever is less.

(c) If a resident who has paid with private funds becomes eligible for Medicaid services, the licensee must accept payment from the Department from the date of eligibility forward as payment in full. The licensee must reimburse the resident or the resident's representative within 30 calendar days after the licensee receives payment from the Department for any private payment received after the resident became eligible for Medicaid services.

(d) The licensee must act in good faith to reduce the charge to a resident who has left the home by seeking a new resident to fill the vacancy.

(e) The licensee must refund any unused advance payment to the resident, or the resident's representative as appropriate, within 30 calendar days after the resident dies or leaves the home.

(f) If the adult foster home closes or the licensee gives written notice for the resident to leave, the licensee waives the right to collect any fees beyond the date of closure or the resident's departure, whichever is sooner.

(g) If a resident dies or leaves an adult foster home due to neglect or abuse at the adult foster home that is substantiated by a Department investigator, or due to conditions of imminent danger of life, health, or safety, the licensee may not charge the resident beyond the resident's last day in the home.

(h) The refund policies in these rules also apply to refunds for resident moves and transfers as described in OAR 411-050-0645.

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, 443.880, 443.790

Stats. Implemented: ORS 443.001-004, 443.705-825, 443.875, 443.991

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0435, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 15-2015, f. 6-24-15, cert. ef. 6-28-155; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0625
Qualification and Training Requirements

(1) APPLICANT AND LICENSEE QUALIFICATIONS. An adult foster home applicant and licensee must meet and maintain the requirements specified in this section. An adult foster home applicant and licensee must:

(a) Live in the home that is to be licensed at least five days and nights per week and function as the primary caregiver as defined in OAR 411-050-0602 unless:

(A) There is, or shall be upon licensure, an approved resident manager who lives in the home and works five consecutive days and nights per week as the primary caregiver;

(B) There is, or shall be upon licensure, two approved primary caregivers who live in the home and work three and four consecutive days and nights per week respectively; or

(C) A variance for shift caregivers has been granted according to section (6) of this rule.

(b) Subsections (a)(A), (B), and (C) of this section are not intended to prohibit the occasional and temporary absence of the primary caregiver from the adult foster home;

(c) Be at least 21 years of age;

(d) Possess physical health, mental health, good judgment, and good personal character, including truthfulness, determined necessary by the Department to provide 24-hour care for adults who are older or adults with physical disabilities. An applicant and licensee must have a statement from a physician, nurse practitioner, or physician assistant indicating that the applicant or licensee is physically, cognitively, and emotionally capable of providing care to residents. An applicant or licensee with documented history or substantiated complaints of substance abuse or mental illness must provide evidence satisfactory to the Department of successful treatment, rehabilitation, or references regarding current condition;

(e) Have an approved background check in accordance with OAR 411-050-0620 and maintain that approval as required;

(f) Be literate in the English language and demonstrate the ability to comprehend and communicate in English orally and in writing with the residents and the residents' family members or representatives, emergency personnel (e.g., emergency operator, law enforcement, paramedics, and fire fighters), licensed health care professionals, case managers, Department and local licensing authority staff, and others involved in the care of the residents;

(g) Be able to respond appropriately to emergency situations at all times; and

(h) Have a clear understanding of his or her responsibilities, knowledge of the residents' care plans, and the ability to provide the care specified for each resident; and not be listed on either of the Exclusion Lists.

(2) APPLICANT AND LICENSEE TRAINING REQUIREMENTS.

(a) Applicants and licensees must have the education, experience, and training to meet the requirements of the requested classification of the home. (See OAR 411-050-0630)

(b) A potential applicant or applicant must complete the following training requirements prior to obtaining a license:

(A) Attend a Department-approved orientation program conducted by the local licensing authority responsible for the licensing of the proposed adult foster home;

(B) Attend the Department's Ensuring Quality Care Course and pass the examination to meet application requirements for licensure;

(i) Potential applicants and applicants who fail the first examination may take the examination a second time; however, successful completion of the examination must take place within 90 calendar days of the end of the Department's Ensuring Quality Care Course.

(ii) Potential applicants and applicants who fail a second examination must retake the Department's Ensuring Quality Care Course prior to repeating the examination.

(C) Comply with the Department's January 1, 2015, student policies for the Department's Ensuring Quality Care Course; and

(D) Have current CPR and First Aid certification.

(i) Accepted CPR and First Aid courses must be provided by or meet the standards of the American Heart Association or the American Red Cross (e.g. the American Safety and Health Institute or MEDIC First Aid).

(ii) CPR or First Aid courses conducted online are only accepted by the Department when an in-person skills competency check is conducted by a qualified instructor meeting the standards of the American Heart Association, the American Red Cross.

(3) FINANCIAL REQUIREMENTS. A licensee applicant and licensee must have the financial ability and maintain sufficient liquid resources to pay the operating costs of the adult foster home for at least two months without solely relying on potential resident income.

(a) If an initial license applicant is unable to demonstrate the financial ability and resources required by this section, the Department may require the applicant to furnish a financial guarantee, such as a line of credit or guaranteed loan, to fulfill the requirements of this rule.

(b) If at any time there is reason to believe an applicant or licensee may not have sufficient financial resources to operate the home in compliance with these rules, the local licensing authority may request additional documentation, which may include verification of the applicant's or licensee's ability to readily access the requested funds. Circumstances that may prompt the request of additional financial information include, but are not limited to, reports of insufficient food, inadequate heat, or failure to pay employees, utilities, rent, or mortgage. Additional documentation of financial resources may include, but are not limited to:

(A) The Department's Verification of Financial Resources form (SDS 0448F) completed and stamped or notarized by the applicant's or licensee's financial institution;

(B) Documentation on letterhead of the applicant's or licensee's financial institution that includes:

(i) The last four digits of the applicant's or licensee's account number;

(ii) The name of the account holder, and if the account is not in the applicant's or licensee's name, verification the applicant or licensee has access to the account's funds;

(iii) The highest and lowest balances for each of the most recent three full months;

(iv) The number of any non-sufficient fund (NSF) payments in each of the last three full months, if any; and

(v) Signature of the banking institution's representative completing the form and date.

(C) Demonstration of cash on hand equal to a minimum of two months of operating expenses.

(c) The local licensing authority must request the least information necessary to verify compliance with this section.

(4) RESIDENT MANAGER REQUIREMENTS. A resident manager must live in the home as specified in section (1)(a) of this rule and function as the primary caregiver under the licensee's supervision. A resident manager must meet and maintain the qualification and training requirements specified in sections (1)(a) through (2)(b)(D) of this rule. The local licensing authority shall verify all the requirements of these rules have been satisfied prior to approval of a resident manager.

(5) FLOATING RESIDENT MANAGER REQUIREMENTS.

(a) A floating resident manager must meet and maintain the qualification and training requirements specified in sections (1)(c) through (2)(b)(D) of this rule, except as indicated in (5)(b) of this rule.

(b) If the licensee has one or more homes within the jurisdiction of more than one local licensing authority, a currently approved floating resident manager is not required to complete the Department-approved orientation in more than one licensing authority's jurisdiction. This exception does not prohibit the local licensing authority within an exempt area from requiring the floating resident manager applicant to attend the local licensing authority's orientation.

(c) The floating resident manager must be oriented to each home prior to providing resident care in each home. Documentation of orientation to every home the floating resident manager works in must be available within each home as stated in section (7) of this rule.

(d) Facility records in each of the homes a floating resident manager is assigned to work must maintain proof the floating resident manager has a current and approved background check.

(e) A floating resident manager may not be used in lieu of a shift caregiver, except on temporary basis, when the regular shift caregiver is unavailable due to circumstances, such as illness, vacation, or termination of employment.

(6) SHIFT CAREGIVER REQUIREMENTS.

(a) Shift caregivers may be used in lieu of a resident manager if granted a written variance by the local licensing authority. Use of shift caregivers detracts from the intent of a home-like environment, but may be allowed for specific resident populations. The type of residents served must be a specialized population with intense care needs, such as those with Alzheimer's disease, AIDS, or head injuries. If shift caregivers are used, each shift caregiver must meet or exceed the experience and training qualifications for the license classification requested.

(b) Shift caregivers must meet and maintain the qualification and training requirements specified in sections (1)(c) through (2)(b)(D) of this rule. The local licensing authority shall verify all the requirements of these rules have been satisfied prior to approval of a shift caregiver.

(7) CAREGIVER ORIENTATION. Prior to providing care to any resident, a resident manager, floating resident manager, and shift caregiver must be oriented to the home and to the residents by the licensee. Orientation must be clearly documented in the facility records. Orientation includes, but is not limited to:

(a) Location of any fire extinguishers;

(b) Demonstration of evacuation procedures;

(c) Instruction of the emergency preparedness plan;

(d) Location of resident records;

(e) Location of telephone numbers for the residents' physicians, the licensee, and other emergency contacts;

(f) Location of medications and the key for the medication cabinet;

(g) Introduction to residents;

(h) Instructions for caring for each resident;

(i) Delegation by a registered nurse for nursing tasks, if applicable; and

(j) Policies and procedures related to Advance Directives. (See OAR 411-050-0645)

(8) EMPLOYMENT APPLICATION. An application for employment in any capacity in an adult foster home must include a question asking whether the person applying for employment has been found to have committed abuse. Employment applications must be retained for at least three years.

(9) EXCLUSION VERIFICATION.

(a) A licensee must verify the resident manager, floating resident manager, and shift caregivers, as applicable, are not listed on either of the Exclusion Lists prior to employment.

(b) Verification of checking the Exclusion Lists must be clearly documented in the facility records.

(10) TRAINING WITHIN FIRST YEAR OF INITIAL LICENSING OR APPROVAL. Within the first year of obtaining an initial license or approval, the licensee, resident manager, floating resident manager, and shift caregivers must complete the Six Rights of Safe Medication Administration and a Fire and Life Safety training as available. The Department or local licensing authority and the Office of the State Fire Marshal or the local fire prevention authority may coordinate the Fire and Life Safety training program.

(11) ANNUAL TRAINING REQUIREMENTS.

(a) Each year after initial licensure, the licensee, resident manager, floating resident manager, and shift caregivers must complete at least 12 hours of Department-approved training related to the care of adults who are older or adults with physical disabilities in an adult foster home setting. Up to four of those hours may be related to the business operation of the adult foster home.

(b) A licensee, resident manager, floating resident manager, and shift caregivers, as applicable, must maintain approved CPR certification.

(c) Registered nurse delegation or consultation, CPR certification and First Aid training, Ensuring Quality Care Course (not including approved EQC refresher courses), adult foster home orientation, Ventilator Assisted Care Course and skills competency checks, or consultation with an accountant do not count toward the required 12 hours of annual training.

(12) SUBSTITUTE CAREGIVER REQUIREMENTS. A substitute caregiver left in charge of the residents for any period of time, may not be a resident, and must at a minimum, meet all of the following qualifications prior to working or training in the home:

(a) Be at least 18 years of age.

(b) Have an approved background check in accordance with OAR 411-050-0620 and maintain that approval as required.

(c) Be literate in the English language and demonstrate the ability to comprehend and communicate in English orally and in writing with the residents and the residents' family members and representatives, emergency personnel (e.g., emergency operator, law enforcement, paramedics, and fire fighters), licensed health care professionals, case managers, Department and local licensing authority staff, and others involved in the care of the residents.

(d) Be able to respond appropriately to emergency situations at all times.

(e) Have a clear understanding of his or her responsibilities, have knowledge of the residents' care plans, and be able to provide the care specified for each resident, including appropriate delegation or consultation by a registered nurse.

(f) Possess physical health, mental health, good judgment, and good personal character, including truthfulness, determined necessary by the Department to provide care for adults who are older or adults with physical disabilities, as determined by reference checks and other sources of information.

(g) Have current CPR and First Aid certification within 30 calendar days of the start of employment.

(A) Accepted CPR and First Aid courses must be provided by or meet the standards of the American Heart Association or the American Red Cross (e.g. the American Safety and Health Institute or MEDIC First Aid).

(B) CPR or First Aid courses conducted online are only accepted by the Department when an in-person skills competency check is conducted by a qualified instructor meeting the standards of the American Heart Association or the American Red Cross.

(h) Not be listed on either of the Exclusion Lists.

(A) Licensees must verify the substitute caregiver is not listed on either of these Exclusion Lists; and

(B) Clearly document that verification in the facility's records.

(13) TRAINING REQUIREMENTS FOR SUBSTITUTE CAREGIVERS.

(a) A substitute caregiver must be oriented to the home and to the residents by the licensee or resident manager prior to the provision of care to any residents. Orientation includes, but is not limited to:

(A) Location of any fire extinguishers;

(B) Demonstration of evacuation procedures;

(C) Instruction of the emergency preparedness plan;

(D) Location of resident records;

(E) Location of telephone numbers for the residents' physicians, the licensee, and other emergency contacts;

(F) Location of medications and the key for the medication cabinet;

(G) Introduction to residents;

(H) Instructions for caring for each resident;

(I) Delegation by a registered nurse for nursing tasks if applicable; and

(J) Education on the policies and procedures related to Advance Directives. (See OAR 411-050-0645)

(b) A substitute caregiver must complete the Department's Caregiver Preparatory Training Study Guide (DHS 9030) and Workbook (DHS 9030-W) and receive instruction in specific care responsibilities from the licensee, resident manager, or floating resident manager prior to working or training in the home. The Workbook must be completed by the substitute caregiver without the help of any others. The Workbook is considered part of the required orientation to the home and residents.

(A) The local licensing authority may grant a variance to the Caregiver Preparatory Training Study Guide and Workbook requirement for a substitute caregiver who:

(i) Holds a current Oregon license as a health care professional, such as a physician, nurse practitioner, physician assistant, registered nurse, or licensed practical nurse; and

(ii) Who demonstrates the ability to provide adequate care to residents based on similar training or at least one year of experience providing direct care to adults who are older or adults with physical disabilities.

(B) A certified nursing assistant (CNA) or certified medical assistant (CMA) must complete the Caregiver Preparatory Training Study Guide and Workbook and have a certificate of completion signed by the licensee.

(c) A substitute caregiver routinely left in charge of an adult foster home for any period that exceeds 48 continuous hours is required to meet the education, experience, and training requirements of a resident manager as specified in this rule. A licensee may not leave a substitute caregiver or concurrent substitute caregivers routinely in charge of the home for any period that exceeds 48 continuous hours within one calendar week. This requirement is not intended to prevent a qualified substitute caregiver from providing relief care in the absence of the primary caregiver, such as for a one or two week vacation. In such an event, the licensee must arrange for the qualified back-up provider to be available as needed.

(14) If a licensee has demonstrated non-compliance with one or more of these rules, the Department may require, by condition, additional training in the deficient area.

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

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

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1995, f. & cert. ef. 3-15-95; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0440, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 50-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0630

Classification of Adult Foster Homes

(1) The local licensing authority shall issue a Class 1, Class 2, or Class 3 adult foster home license only if the qualifications of the applicant, resident manager, floating resident manager, and shift caregivers, as applicable, fulfill the classification requirements of these rules.

(a) After receipt of the completed application materials, including the non-refundable fee, the local licensing authority must investigate the information submitted, including any pertinent information received from outside sources.

(b) The local licensing authority shall not issue a license if unsatisfactory references or a history of substantial non-compliance of the applicant within the last 24 months is verified.

(c) The local licensing authority may issue a Class 1 license if the applicant and resident manager, as applicable, complete the training requirements outlined in OAR 411-050-0625;

(d) The local licensing authority may issue a Class 2 license if the applicant, resident manager, and floating resident manager, as applicable, complete the requirements outlined in OAR 411-050-0625. In addition, these caregivers must each have the equivalent of two years of full time experience providing direct care to adults who are older or adults with physical disabilities;

(e) The local licensing authority may issue a Class 3 license if the applicant, resident manager, floating resident manager, and shift caregivers, as applicable, complete the training requirements outlined in OAR 411-050-0625 and have a current license as a health care professional in Oregon or possess the following qualifications:

(A) Have the equivalent of three years of full time experience providing direct care to adults who are older or adults with physical disabilities and who require full assistance in four or more activities of daily living; and

(B) Have references satisfactory to the Department. The applicant must submit current contact information from at least two licensed health care professionals who have direct knowledge of the applicant's ability and past experience as a caregiver.

(2) The Department may approve a licensee to care for residents requiring ventilator-assisted care. The licensee, resident manager, floating resident manager, or shift caregivers, as applicable, must meet the criteria for a Class 3 home according to section (1)(e) of this rule and comply with the additional requirements for adult foster homes serving residents requiring ventilator-assisted care outlined in OAR 411-050-0660.

(3) To request a change in the classification of a licensed home, at any time other than the license renewal period, the licensee shall submit a written request to the local licensing authority, using the Department's form

DHS 0748, and DHS 0748A as applicable, to amend the licensee's previous application for a license.

(a) The complete request will include all the required information and documentation, as applicable, to demonstrate the applicant meets the standards for the requested classification according to these rules.

(b) Within 60 calendar days' receipt of the complete written request, the local licensing authority will investigate the information provided and shall:

(A) Approve the applicant's request and issue an amended license with the requested classification; or

(B) Deny the applicant's request, unless the applicant submits written notification to withdraw the requested change in classification. If the request is denied, the Department shall provide the applicant with notice and an opportunity for a contested case hearing pursuant to ORS 183. The Notice shall state the reasons for the denial and shall be served personally upon the applicant or by certified or registered mail. Any request for a contested case hearing must be submitted to the Department, in writing, by the applicant within 10 days of service.

(4) A licensee may only admit or continue to care for residents whose impairment levels are within the classification of the licensed home.

(a) A licensee with a Class 1 license may only admit residents who require assistance in no more than four activities of daily living.

(b) A licensee with a Class 2 license may provide care for residents who require assistance in all activities of daily living, but require full assistance in no more than three activities of daily living.

(c) A licensee with a Class 3 license may provide care for residents who require full assistance in four or more activities of daily living, but only one resident who requires bed-care or full assistance with all activities of daily living, not including cognition or behavior.

(5) A licensee must request, in writing, a variance from the local licensing authority if:

(a) A new resident wishes to be admitted whose impairment level exceeds the license classification;

(b) A current resident becomes more impaired, exceeding the license classification; or

(c) There is more than one resident in the home who requires full bed-care or full assistance with all activities of daily living, not including cognition or behavior.

(6) The local licensing authority may grant a variance that allows the resident to be admitted or remain in the adult foster home. The local licensing authority must respond in writing within 30 calendar days after receipt of the licensee's written variance request. The licensee must prove the following criteria are met by clear and convincing evidence:

(a) It is the choice of the resident to reside in the home;

(b) The licensee is able to provide appropriate care and service to the resident in addition to meeting the care and service needs of the other residents;

(c) Additional staff is hired to meet the additional care requirements of all residents in the home as necessary;

(d) Outside resources are available and obtained to meet the resident's care needs;

(e) The variance shall not jeopardize the care, health, safety, or welfare of the residents; and

(f) The licensee is able to demonstrate how all occupants shall be safely evacuated in three minutes or less.

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

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

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1995, f. & cert. ef. 3-15-95; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0443, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0632
Capacity

(1) Residents must be limited to five adults who require care and are unrelated to the licensee and resident manager by blood, marriage, or adoption.

(2) The number of residents permitted to reside in an adult foster home is determined by the ability of the staff to meet the care needs of the residents, the fire and life safety standards for evacuation, and compliance with the facility standards of these rules.

(3) The licensee must demonstrate, to the local licensing authority's satisfaction, the ability to meet the needs of the residents, in addition to, caring for any children or relatives beyond the license capacity of the adult foster home.

(4) The local licensing authority's determination of maximum capacity must ensure:

(a) The ratio of at least one caregiver per five residents, including any day care individuals and others requiring care or supervision except as allowed under section (5) of this rule.

(b) Children over the age of five have a bedroom available that is separate from the child's parents.

(c) The well-being of the household, including any children or other family members, shall not be jeopardized.

(d) The care needs of day care individuals shall be met.

(5) When a family member requires care in a home where the licensee is the primary live-in caregiver, a maximum capacity of five unrelated residents are allowed if the following criteria are met:

(a) The licensee must be able to demonstrate the ability to evacuate all occupants from the adult foster home within three minutes or less (See OAR 411-050-0650).

(b) The licensee must have sufficient, qualified staff and demonstrate the ability to provide appropriate care for all residents (See OAR 411-050-0645).

(c) There must be an additional 40 square feet of common living space for each person above the five residents (See OAR 411-050-0650).

(d) Bathrooms and bedrooms must meet the requirements of OAR 411-050-0650.

(e) The care needs of day care individuals must be within the classification of the license and any conditions imposed on the license.

(f) The well-being of the household, including any children or other family members, shall not be jeopardized.

(6) If day care individuals are in the home, the licensee must have arrangements for the day care individuals to sleep in areas other than a resident's bed, a resident's room, or space designated as common use, in accordance with OAR 411-050-0650.

(7) If room and board tenants are in the home, each tenant must have:

(a) An approved background check in accordance with OAR 407-007-0200 to 407-007-0370 (Criminal Records and Abuse Check Rules).

(b) A tenancy agreement.

(c) A copy of the current tenancy agreement signed and dated by the tenant.

(8) To request a change to the maximum capacity of a licensed home at any time other than the license renewal period, the licensee shall submit to the local licensing authority a written request using the Department's form, DHS 0749, to amend the licensee's previous application for a license.

(a) The complete request will include:

(A) All the required information and documentation, as applicable, to demonstrate the applicant meets the standards for the requested capacity according to these rules; and

(B) A $20 non-refundable fee for each additional resident bed requested.

(b) Within 60 calendar days' receipt of the complete written request, the local licensing authority must investigate the information provided and must:

(A) Approve the request and issue an amended license with the requested capacity; or

(B) Deny the applicant's request, unless the applicant submits written notification to withdraw the requested change in classification. If the request is denied, the Department shall provide the applicant with notice and an opportunity for a contested case hearing pursuant to ORS 183. The notice shall state the reasons for the denial and shall be served personally upon the applicant or by certified or registered mail. Any request for a contested case hearing must be submitted to the Department, in writing, by the applicant within 10 days of service.

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

Stats. Implemented: ORS 443.001-004, 443.705-825, 443.875, & 443.991

Hist. SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0408, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0635
Issuance

(1) The local licensing authority must issue a license within 60 calendar days after the completed application materials have been received if the home and applicant are in compliance with these rules.

(2) The license specifies the type of license and includes:

(a) The name of the licensee and the name of the resident manager or shift caregivers as applicable, who have met the requirements to operate the adult foster home.

(b) The address of the premises to which the license applies.

(c) The license classification and level if applicable.

(d) The maximum number of residents.

(e) The expiration date.

(3) The licensee must be given a copy of the Department's inspection report form as follows:

(a) INITIAL LICENSE. Form SDS 516 identifying any areas of noncompliance and a time frame for correction.

(b) RENEWAL LICENSE. Form SDS 517A and, if applicable, form SDS 517B citing any violations. The SDS 517B must specify a time frame for correction of each violation. The time frame for correction may not exceed 30 calendar days from the date of inspection.

(4) The licensee must post the most recent inspection reports in the entry of the home or an equally prominent place and must, upon request, provide a copy of the reports to each resident, person applying for admission to the home, or the legal representative, guardian, or conservator of a resident.

(5) The Department may attach conditions to the license that limit, restrict, or specify other criteria for operation of the home. The conditions must be visibly posted with the license.

(6) The local licensing authority shall not issue an initial license unless:

(a) The applicant and adult foster home are in compliance with ORS 443.705 to 443.825 and these rules;

(b) The applicant currently operates, or has operated, any other facility licensed by the applicant in substantial compliance with ORS 443.705 to 443.825;

(c) The local licensing authority has completed an inspection of the adult foster home that demonstrates the home is in compliance with these rules;

(d) The Department has completed a background check in accordance with OAR 411-050-0620;

(e) The local licensing authority has reviewed the record of sanctions available from the local licensing authority's files;

(f) The local licensing authority has determined that the nursing assistant registry maintained under 42 CFR 483.156 contains no finding that the applicant or any nursing assistant employed by the applicant has been responsible for abuse;

(g) The local licensing authority has verified the applicant is not listed on either of the Exclusion Lists; and

(h) The applicant has demonstrated to the local licensing authority the financial ability and resources necessary to operate an adult foster home.

(7) A license is valid for one year unless revoked or suspended by the Department.

(8) When the Department reviews a license and determines that the convenience of both the licensee and the Department will be served, a license period may be changed to match the renewal schedule of another license held by the same licensee. The request for a schedule change may be made by either the Department or the licensee. No license period may extend beyond one year.

(9) In seeking an initial license, the burden of proof to establish compliance with ORS 443.705 to 443.825, and these rules, is upon the applicant of the adult foster home.

(10) The local licensing authority shall not issue a license to operate an additional adult foster home to a licensee who has failed to achieve and maintain substantial compliance with the rules and regulations while operating his or her existing home or homes.

(11) PROVISIONAL LICENSE. Notwithstanding any other provision of this rule or ORS 443.725 or 443.738, the local licensing authority may issue a 60-day provisional license to a qualified person.

(a) A provisional license may be issued if the local licensing authority determines it is in the best interests of the residents currently residing in the home, and any of the following exist:

(A) An emergency situation exists after receiving notification that a licensed provider is no longer overseeing the operation of an adult foster home.

(B) A new applicant has submitted an application and bed fee for a license to operate a currently licensed home. The applicant has demonstrated a good faith effort to submit a timely and complete application, but the application process cannot be completed before the expiration date of the current license.

(b) A person is considered qualified for a provisional license if he or she:

(A) Is at least 21 years of age.

(B) Has the necessary experience working with adults who are older or adults with physical disabilities to potentially qualify for the license classification of the home.

(C) Fully understands and has the ability to meet the residents' care needs.

(D) Meets the requirements of a substitute caregiver as described in OAR 411-050-0625.

(c) A provisional license may be extended one time for a period of 30 calendar days if an applicant has demonstrated a good faith effort to complete the application process and obtain the required qualifications and trainings.

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

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

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0415, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0640
Renewal Application and Fees

(1) At least 60 calendar days prior to the expiration of a license, the local licensing authority must send a reminder notice and renewal application to the licensed provider. The local licensing authority must investigate any information in the renewal application and conduct an unannounced inspection of the adult foster home prior to the license renewal.

(2) A separate application is required for each location where an adult foster home is to be operated.

(3) RENEWAL APPLICATION REQUIREMENTS. To renew an adult foster home license, the licensee must complete the Department's Renewal Application form (SDS 448C) and submit the form to the local licensing authority with the non-refundable fee prior to the expiration date of the current license. Timely submission of the renewal application and non-refundable fee shall keep the license in effect until the local licensing authority or the Department takes action.

(a) The renewal application is not complete until all of the required application information is submitted to the local licensing authority.

(b) A renewal application remaining incomplete at the time of license expiration or failure to provide accurate information on the renewal application shall result in the denial of the application.

(4) The license renewal application must include:

(a) Complete contact information for the licensee, including:

(A) A mailing address if different from the adult foster home; and

(B) A business address for electronic mail, if applicable.

(b) The maximum resident capacity;

(c) Identification of:

(A) Any relatives needing care;

(B) The maximum number of any room and board tenants;

(C) The maximum number of day care individuals; and

(D) The names of any other occupants in the home.

(d) A Health History and Physician or Nurse Practitioners' Statement (form SDS 0903). The Health History and Physician or Nurse Practitioners' Statement must be updated every third year or sooner if there is reasonable cause for health concerns;

(e) FINANCIAL INFORMATION FOR THE HOME'S FIRST LICENSE RENEWAL. A completed Financial Information Worksheet (form SDS 0448A) demonstrating the financial ability to maintain sufficient liquid resources to pay the home's operating costs for at least two months;

(f) If the home is leased or rented, a copy of the current signed and dated lease or rental agreement. The agreement must be a standard lease or rental agreement for residential use and include the following:

(A) The owner and landlord's name;

(B) Verification that the rent is a flat rate; and

(C) Signatures and date signed by the landlord and applicant, as applicable;

(g) Documentation of a current approved background check for each subject individual as described in OAR 411-050-0620;

(h) A $20 per bed non-refundable fee for each non-relative resident;

(i) If the licensee intends to use a resident manager, floating resident manager, or shift caregivers, the Department's supplemental application (form SDS 448B) completed by the applicant or applicants, as appropriate;

(j) Written information describing the operational plan for the adult foster home, including:

(A) The use of substitute caregivers and other staff;

(B) A plan of coverage for the absence of the resident manager or the shift caregivers, if applicable; and

(C) The name of a qualified back-up licensee, approved resident manager, or floating resident manager who does not live in the home but has been oriented to the home. The licensee must submit a signed agreement with the listed back-up provider annually and maintain a copy in the facility records.

(k) Copies of the home's Residency Agreement forms if changes to the original forms reviewed by the Local Licensing Authority are proposed.

(l) Proof of required continuing education credits as specified in OAR 411-050-0625.

(5) LATE RENEWAL REQUIREMENTS (UNLICENSED ADULT FOSTER HOME). The home shall be treated as an unlicensed facility, subject to civil penalties, if the required renewal information and fee are not submitted to the local licensing authority prior to the license expiration date and residents remain in the home. (See OAR 411-050-0685)

(6) The local licensing authority shall investigate the information submitted, review the licensing records for the applicant, conduct an inspection of the home, and provide the licensee a copy of the Department's inspection report (form SDS 517A and, if applicable, form SDS 517B) citing any violations and specifying a time frame for correction not to exceed 30 days.

(7) The Department may attach conditions to the license that limit, restrict, or specify other criteria for operation of the home. The licensee must visibly post the conditions, if applicable, with the license according to OAR 411-050-0645.

(8) The Department may deny a renewal application if cited violations are not corrected within the time frame specified by the local licensing authority.

(9) The local licensing authority shall not renew a license unless the following requirements are met:

(a) The applicant and the adult foster home are in compliance with ORS 443.705 to 443.825 and these rules, including any applicable conditions and other final orders of the Department;

(b) The local licensing authority has completed an inspection of the adult foster home;

(c) The Department has completed a background check in accordance with OAR 411-050-0620;

(d) The local licensing authority has reviewed the record of sanctions available from the local licensing authority's files;

(e) The local licensing authority has determined the nursing assistant registry maintained under 42 CFR 483.156 contains no finding that the licensee or any nursing assistant employed by the licensee has been responsible for abuse; and

(f) The local licensing authority has determined the licensee is not listed on either of the Exclusion Lists.

(10) In seeking the renewal of a license when an adult foster home has been licensed for less than 24 months, the burden of proof to establish compliance with ORS 443.705 to 443.825 and these rules is upon the licensee.

(11) In seeking the renewal of a license when an adult foster home has been licensed for 24 or more continuous months, the burden of proof to establish noncompliance with ORS 443.705 to 443.825 and these rules is upon the Department.

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

Stats. Implemented: ORS 443.001-004, 443.705-825, 443.875, 443.991

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 9-2007, f. 6-27-07, cert. ef. 7-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0420, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; SPD 42-2013(Temp), f. & cert. ef. 10-16-13 thru 4-13-14; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 50-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0642
Variances

(1) An applicant or licensee may request a variance to the provisions of these rules. The variance request must be in writing and must include clear and convincing evidence that:

(a) The requested variance does not jeopardize the care, health, welfare, or safety of the residents;

(b) All of the residents' needs shall be met; and

(c) All residents, in addition to other occupants in the home, may be evacuated in three minutes or less.

(2) VARIANCES NOT ALLOWED. Notwithstanding section (1) of this rule, no variance shall be granted by the local licensing authority from a regulation or provision of the rules pertaining to:

(a) Resident capacity as described in OAR 411-050-0632.

(b) Minimum age of licensee and any caregivers as described in OAR 411-050-0625.

(c) The training requirements of a licensee and all other caregivers except as allowed for provisional licenses as described in OAR 411-050-0635, or when a substitute caregiver holds an Oregon health care professional license as described in OAR 411-050-0625.

(d) Standards and practices for care and services as described in OAR 411-050-0655).

(e) Inspections of the facility as described in OAR 411-050-0670.

(f) Background checks as described in OAR 411-050-0620.

(3) The local licensing authority shall not grant a variance request to any rule that is inconsistent with Oregon Revised Statutes or 42 CFR 441.301(c)(2)(xiii) and 42 CFR 441.530(a)(1)(vi) (See OAR 411-050-0655(4)).

(4) The local licensing authority shall not grant a variance request related to fire and life safety without prior consultation with the Department.

(5) In making a determination to grant a variance, the local licensing authority must consider the licensee's history of compliance with rules governing adult foster homes or other long-term care facilities for adults who are older or adults with physical disabilities in Oregon and any other jurisdiction, if appropriate. The local licensing authority must determine that the variance is consistent with the intent and purpose of these rules before granting the variance. (See OAR 411-050-0600). The local licensing authority must respond, in writing, within 30 days of receiving a request for a variance. The written response must include the frequency of renewal.

(6) A variance is not effective until granted in writing by the local licensing authority. Variances are reviewed pursuant to these rules. If applicable, the licensee must re-apply for a variance at the time of license renewal, or more often if determined necessary by the local licensing authority.

(7) In seeking a variance, the burden of proof that the requirements of these rules have been met is upon the applicant or licensee.

(8) If a variance to any provision of these rules is denied, the applicant or licensee may request a meeting with the local licensing authority.

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

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

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0442, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0645
Operational Standards

(1) GENERAL PRACTICES.

(a) A licensee must own, rent, or lease the home to be licensed, however, the local licensing authority may grant a variance to churches, hospitals, non-profit associations, or similar organizations. If a licensee rents or leases the premises where the adult foster home is located, the licensee may not enter into a contract that requires anything other than a flat rate for the lease or rental. A licensed provider of a building where an adult foster home is located may not allow the owner, landlord, or lessor to interfere with the admission, transfer, or voluntary or involuntary move of any resident in the adult foster home unless the owner, landlord, or lessor is named on the license.

(b) Each adult foster home must comply with:

(A) All applicable local business license, zoning, building, and housing codes.

(B) The Fair Housing Act.

(C) State and local fire and safety regulations for a single-family residence, and Oregon Fire Code, Appendix L.

(D) Federal regulations governing HCB Settings. Providers initially licensed before January 1, 2016 must fully comply with Home and Community-Based Services and Settings and Person-Centered Service Plans, OAR chapter 411, division 004, by no later than September 1, 2018.

(c) ZONING. Adult foster homes are subject to applicable sections of ORS 197.660 to 197.670.

(d) COOPERATION AND ACCESS. The licensee must cooperate with the Department, Centers for Medicare and Medicaid Services (CMS), and local licensing and investigative personnel in inspections, complaint

investigations, planning for resident care, application procedures, and other necessary activities.

(A) Department, CMS, local licensing, and investigative personnel must be provided access to all resident and facility records and may conduct private interviews with residents.

(B) The State Long-Term Care Ombudsman must be provided access to all resident and facility records. Deputy Ombudsman and Certified Ombudsman Volunteers must be provided access to facility records, and with written permission from the resident or the resident's legal representative, may have access to resident records. (See OAR 114-005-0030).

(e) CONFIDENTIALITY. Information related to residents must be kept confidential, except as may be necessary in the planning or provision of care or medical treatment, or related to an inspection, investigation, or sanction action under these rules.

(f) TRANSPORTATION. A licensee must arrange for or provide appropriate transportation for residents when needed.

(g) STAFFING STANDARDS. The licensee must have qualified caregivers, including awake caregivers as necessary, sufficient in number to meet the 24-hour needs of each resident in addition to caring for any children or relatives beyond the license capacity of the adult foster home. In addition, the licensee must comply with the following standards:

(A) A licensee may not employ a resident manager, floating resident manager, or shift caregiver who does not meet or exceed the qualifications, training, and classification standards for the adult foster home as described in OAR 411-050-0625 and 411-050-0630.

(B) A licensee may not employ or allow any caregiver to train or work in the home who is on either of the Exclusion Lists.

(h) ABSENCE OF A PRIMARY CAREGIVER. If a primary caregiver or a shift caregiver is absent from the home for 10 days or more, the licensee must notify the local licensing authority, in writing, at least seven days before the primary caregiver's absence or immediately upon knowing of the absence. Notification must state the reason for and anticipated length of the absence. The licensee must submit a staffing plan to the local licensing authority that demonstrates coverage to meet the needs of the residents during the primary caregiver's absence and is signed by the back-up provider.

(i) CHANGE OF PRIMARY CAREGIVER. If a primary caregiver or a shift caregiver changes during the period the license covers, the licensee must notify the local licensing authority within 24 hours and identify who is providing care.

(A) If a licensee assumes the role as the primary caregiver or shift caregiver when there has been a change in primary caregiver, the licensee must submit an updated plan of 24-hour coverage to the local licensing authority within seven days.

(B) If a resident manager, floating resident manager, or shift caregiver changes, the licensee must submit a request for a change of resident manager, floating resident manager, or shift caregiver, as applicable, to the local licensing authority along with:

(i) The Department's supplemental application form (SDS 448B) completed by the resident manager applicant, floating resident manager applicant, or shift caregiver applicant;

(ii) A completed Health History and Physician or Nurse Practitioner's Statement (form SDS 903) for the new applicant;

(iii) Documentation of the initiation of or a copy of an approved background check; and

(iv) A $10 non-refundable fee.

(C) When there is a change in primary caregiver, an approved floating resident manager may assume the responsibilities of the live-in, primary caregiver until a new primary caregiver is employed. If a new primary caregiver is not employed within 60 calendar days, the floating resident manager must be designated as the home's resident manager and the licensee must notify the local licensing authority of the change in status.

(D) The local licensing authority shall issue a revised license when there is a change in a primary caregiver who is identified on the license.

(j) UNEXPECTED AND URGENT STAFFING NEED. If the local licensing authority determines an unexpected and urgent staffing need exists, the local licensing authority may authorize a person who has not completed the Department's current Ensuring Quality Care Course and passed the current examination to act as a resident manager or shift caregiver until training and testing are completed, or for 60 calendar days, whichever period is shorter. The licensee must notify the local licensing authority of the unexpected and urgent staffing need in writing and satisfactorily demonstrate:

(A) The licensee's inability to live in the home and act as the primary caregiver;

(B) The licensee's inability to find a qualified resident manager or shift caregiver, as applicable; and

(C) The proposed staff person is 21 years of age and meets the requirements of a substitute caregiver for the adult foster home as described in OAR 411-050-0625 and 411-050-0630.

(k) RESPONSIBILITY. A licensee is responsible for the supervision, training, and overall conduct of all caregivers, family members, and friends when acting within the scope of their employment, duties, or when present in the home.

(l) SEXUAL ABUSE. Sexual abuse, as defined in OAR 411-020-0002 (Adult Protective Services), is prohibited.

(m) COMMUNICATION.

(A) Applicants for an initial license must obtain and provide to the local licensing authority a current, active business address for electronic mail before obtaining a license.

(B) A licensee must notify the local licensing authority within 24 hours upon a change in the home's business address for electronic mail.

(C) A licensee must notify the local licensing authority, the residents and the resident's family members, representatives, and case managers, as applicable, of any change in the telephone number for the licensee or the adult foster home within 24 hours of the change.

(D) A licensee must notify the local licensing authority in writing before any change of the licensee's residence or mailing address.

(2) SALE OR LEASE OF EXISTING ADULT FOSTER HOMES AND TRANSFER OF LICENSES.

(a) A license is not transferable and does not apply to any location or person other than the location and person indicated on the license obtained from the local licensing authority.

(b) The licensee must inform real estate agents, prospective buyers, lessees, and transferees in all written communication, including advertising and disclosure statements, that the license to operate the adult foster home is not transferable and the licensee must refer them to the local licensing authority for information about licensing.

(c) When a home is to be sold or otherwise transferred or conveyed to another person who intends to operate the home as an adult foster home, that person must apply for and obtain a license from the local licensing authority before the transfer of operation of the home.

(d) The licensee must promptly notify the local licensing authority in writing about the licensee's intent to close or convey the adult foster home to another person. The licensee must provide written notice to the residents and the residents' representatives and case managers, as applicable, according to section (13) of this rule.

(e) The licensee must inform a person intending to assume operation of an existing adult foster home that the residents currently residing in the home must be given at least 30 calendar days' written notice of the licensee's intent to close the adult foster home for the purpose of conveying the home to another person.

(f) The licensee must remain licensed and responsible for the operation of the home and care of the residents in accordance with these rules until the home is closed and the residents have been relocated, or the home is conveyed to a new licensee who is licensed by the local licensing authority at a level appropriate to the care needs of the residents in the home.

(3) FORECLOSURE.

(a) A licensee must provide written notification to the local licensing authority within 10 calendar days after receipt of any notice of default, or any notice of potential default, with respect to a real estate contract, trust deed, mortgage, or other security interest affecting any property occupied or used by the licensee.

(b) The licensee must provide a copy of the notice of default or warning of potential default to the local licensing authority.

(c) The licensee must provide written updates to the local licensing authority at least every 30 days until the default or warning of potential default has been resolved and no additional defaults or potential defaults have been declared and no additional warnings have been issued. Written updates must include:

(A) The current status on what action has been or is about to be taken by the licensee with respect to the notice received.

(B) The action demanded or threatened by the holder of the security interest.

(C) Any other information reasonably requested by the local licensing authority.

(d) The licensee must provide written notification within 24 hours to the local licensing authority upon final resolution of the matters leading up to or encompassed by the notice of default or the notice warning of potential default.

(e) If the subject default property is licensed as an adult foster home, the licensee must provide written notification of the following within 24 hours to the local licensing authority, and all the residents and the residents' representatives, if applicable, regarding:

(A) The filing of any litigation regarding such security interest, including the filing of a bankruptcy petition by or against the licensee or an entity owning any property occupied or used by the licensee;

(B) The entry of any judgment with respect to such litigation;

(C) The passing of the date 40 days before any sale scheduled pursuant to the exercise of legal rights under a security interest, or a settlement or compromise related thereto, of the licensee's property or property occupied or used by the licensee; and

(D) The sale, pursuant to the exercise of legal rights under a security interest, or a settlement or compromise related thereto, of the licensee's property or property occupied or used by the licensee.

(4) MEALS.

(a) Three nutritious meals must be served daily at times consistent with those in the community. Each meal must include food from the basic food groups according to the United States Department of Agriculture (USDA's) My Plate and include fresh fruit and vegetables when in season.

(b) Meals must reflect consideration of a resident's preferences and cultural and ethnic background. This does not mean the licensee must prepare multiple, unique meals for the residents at the same time.

(c) A schedule of meal times and menus for the coming week must be prepared and posted weekly in a location accessible to residents and families.

(A) Meal substitutions for scheduled menu items in compliance with section (4)(a) of this rule are acceptable and must be documented on, or attached to, the weekly menu.

(B) The licensee must maintain the weekly menus for a minimum of the 12 most recent months during which the home has conducted business.

(C) The licensee must support the resident's right to access food at any time. Limitations may only be used when there is a health or safety risk, as stated in OAR 411-050-0655, and when a written informed consent is obtained. Providers initially licensed before January 1, 2016 have until September 1, 2018 to fully comply with this HCB Settings requirement, OAR 411-050-0645(4)(c)(C).

(D) If a resident misses a meal at a scheduled time, an alternative meal must be made available.

(d) There must be no more than a 14-hour span between the evening and morning meals. Snacks do not substitute for a meal in determining the 14-hour span. Nutritious snacks and liquids must be offered to fulfill each resident's nutritional requirements.

(e) Food may not be used as an inducement to control the behavior of a resident.

(f) Home-canned foods must be processed according to the guidelines of the Oregon State University Extension Service. Freezing is the most acceptable method of food preservation. Milk must be pasteurized.

(g) Special consideration must be given to a resident with chewing difficulties or other eating limitations. Special diets must be followed, as prescribed in writing, by the resident's physician, nurse practitioner, or physician assistant.

(h) Adequate storage must be available to maintain food at a proper temperature, including a properly working refrigerator. Storage and food preparation areas must be free from food that is spoiled or expired.

(i) The household utensils, dishes, glassware, and household food may not be stored in bedrooms, bathrooms, or living areas.

(j) Meals must be prepared and served in the home where the residents live. Payment for meals eaten away from the home for the convenience of the licensee (e.g., restaurants, senior meal sites) is the responsibility of the licensee.

(A) Meals and snacks, as part of an individual recreational outing by choice, are the responsibility of the resident.

(B) Payment for food beyond the required three meals and snacks are the responsibility of the resident.

(k) Utensils, dishes, and glassware must be washed in hot soapy water, rinsed, and stored to prevent contamination. A dishwasher with a sani-cycle is recommended.

(l) Food preparation areas and equipment, including utensils and appliances, must be clean, free of offensive odors, and in good repair.

(5) TELEPHONE.

(a) The home must have a working landline and corded telephone with a listed number that is separate from any other number the home has, such as, but not limited to, internet or fax lines, unless the system includes features that notify the caregiver of an incoming call, or automatically switches to the appropriate mode. If a licensee has a caller identification service on the home number, the blocking feature must be disabled to allow incoming calls to be received unhindered. A licensee may have only one phone line as long as the phone line complies with the requirements of these rules. Voice over internet protocol (VoIP), voice over broadband (VoBB), or cellular telephone service may not be used in place of a landline.

(b) The licensee must make a telephone that is in good working order available and accessible for the residents use with reasonable accommodation for privacy during telephone conversations. A resident with a hearing impairment, to the extent the resident may not hear a normal telephone conversation, must be provided with a telephone that is amplified with a volume control or a telephone that is hearing aid compatible.

(c) Restrictions on the use of the telephone by the residents must be specified in the written Residency Agreement and may not violate the residents' rights. Individual restrictions must be well documented in the resident's care plan.

(6) FACILITY RECORDS.

(a) Facility records must be kept current, maintained in the adult foster home, and made available for review upon request. Facility records include, but are not limited to:

(A) Proof the licensee and all subject individuals have a background check approved by the Department as required by OAR 411-050-0620.

(B) Proof the licensee and all other caregivers have met and maintained the minimum qualifications as required by OAR 411-050-0625, including:

(i) Proof of required continuing education. Documentation must include the date of each training, subject matter, name of agency or organization providing the training, and number of Department-approved classroom hours.

(ii) Completed certificates to document the substitute caregivers' completion of the Department's Caregiver Preparatory Training Study Guide and Workbook and to document the resident manager, floating resident manager, and shift caregivers, as applicable, completion and passing of the Department's Ensuring Quality Care Course and examination.

(iii) Documentation of orientation to the adult foster home for the resident manager, floating resident manager, shift caregivers, and substitute caregivers, as applicable.

(iv) Employment applications and the names, addresses, and telephone numbers of all caregivers employed or used by the licensee.

(v) Verification that all caregivers are not listed on either of the Exclusion Lists.

(C) Copies of notices sent to the local licensing authority pertaining to changes in the resident manager, floating resident manager, shift caregiver, or other primary caregiver.

(D) Proof of required vaccinations for animals on the premises.

(E) Well water tests, if required, according to OAR 411-050-0650. Test records must be retained for a minimum of three years.

(F) Residency Agreements with all residents and, if applicable, specialized contracts with the Department, and tenancy agreements with room and board tenants.

(G) Records of evacuation drills according to OAR 411-050-0650, including the date, time of day, evacuation route, length of time for evacuation of all occupants, names of all residents and occupants, and names of residents and occupants that required assistance. The records must be kept at least three years.

(H) The Department's current Adult Foster Home Back-Up Agreement form (SDS 350) completed by the current back-up provider and the licensee, as stated in OAR 411-050-0610 and 411-050-0640.

(b) REQUIRED POSTED ITEMS. The following items must be posted in one location in the entryway or other equally prominent place in the home where residents, visitors, and others may easily read them:

(A) The adult foster home license;

(B) Conditions attached to the license, if any;

(C) A copy of a current floor plan meeting the requirements of OAR 411-050-0650;

(D) The Residents' Bill of Rights;

(E) The home's policies as stated in the current Residency Agreement that has been reviewed for compliance with these rules by the local licensing authority;

(F) The Department's procedure for making complaints;

(G) The Long-Term Care Ombudsman poster;

(H) The Department's inspection forms (form SDS 517A and, if applicable, form SDS 517B), including how corrections were made since the last annual inspection;

(I) The Department's notice pertaining to the use of any intercoms and monitoring devices that may be used in the adult foster home; and

(J) A weekly menu according to section (4) of this rule.

(c) POST BY PHONE. Emergency telephone numbers, including the contact number for at least one back-up provider who has agreed to respond in person in the event of an emergency and an emergency contact number for the licensee must be readily visible and posted by a central telephone in the adult foster home.

(7) RESIDENT RECORDS.

(a) An individual resident record must be developed, kept current, and readily accessible on the premises of the home for each individual admitted to the adult foster home. The record must be legible and kept in an organized manner so as to be utilized by staff. The record must contain the following information:

(A) A complete initial screening assessment and general information form (SDS 902) as described in OAR 411-050-0655.

(B) Documentation on form SDS 913 that the licensee has informed private-pay residents of the availability of a long-term care assessment.

(C) Documentation that the licensee has informed all residents of the right to formulate an Advance Directive.

(D) FINANCIAL INFORMATION:

(i) Detailed records and receipts, if the licensee manages or handles a resident's money. The Resident Account Record (form SDS 713) or other expenditure forms may be used if the licensee manages or handles a resident's money. The record must show amounts and sources of funds received and issued to, or on behalf of, the resident and be initialed by the person making the entry. Receipts must document all deposits and purchases of $5 or more made on behalf of a resident.

(ii) Residency Agreement signed and dated by the resident or the resident's representative may be kept in a separate file, but must be made available for inspection by the local licensing authority.

(E) Medical and legal information, including, but not limited to:

(i) Medical history, if available.

(ii) Current prescribing practitioner orders.

(iii) Nursing instructions, delegations, and assessments, as applicable.

(iv) Completed medication administration records retained for at least the last six months or from the date of admission, whichever is less. (Older records may be stored separately).

(v) Copies of Guardianship, Conservatorship, Advance Directive for Health Care, Power of Attorney, and Physician's Order for Life Sustaining Treatment (POLST) documents, as applicable.

(F) A complete, accurate, and current care plan.

(G) Effective January 1, 2017 and no later than February 28, 2018, documentation that supports or eliminates any individually-based limitation, as described in OAR 411-050-0655(4).

(H) A copy of the current house policies, as identified in the current Residency Agreement, and the current Resident's Bill of Rights, signed and dated by the resident or the resident's representative.

(I) SIGNIFICANT EVENTS. A written report (using form SDS 344 or its equivalent) of all significant incidents relating to the health or safety of the resident, including how and when the incident occurred, who was involved, what action was taken by the licensee and staff, as applicable, and the outcome to the resident.

(J) NARRATIVE OF RESIDENT'S PROGRESS. Narrative entries describing each resident's progress must be documented at least weekly and maintained in each resident's individual record. All entries must be signed and dated by the person writing them.

(K) Non-confidential information or correspondence pertaining to the care needs of the resident.

(b) ACCESS TO RESIDENT RECORDS.

(A) Resident records must be readily available at the adult foster home to residents, the residents' representatives or other legally authorized persons, all caregivers working in the home, and the Department, the local licensing authority, the investigative authority, case managers, and the Centers for Medicare and Medicaid Services (CMS) for the purpose of conducting inspections or investigations.

(B) The State Long-Term Care Ombudsman must be provided access to all resident and facility records. A Deputy Ombudsman and Certified Ombudsman Volunteers must be provided access to facility records relevant to caregiving and resident records with written permission from the resident or the resident's representative. (See OAR 114-005-0030).

(c) RECORD RETENTION. Records, including any financial records for residents, must be kept for a period of three years from the date the resident left the home.

(d) CONFIDENTIALITY. In all other matters pertaining to confidential records and release of information, licensees must be guided by the principles and definitions described in OAR chapter 411, division 005 (Privacy of Protected Information).

(8) RESIDENCY AGREEMENT. The current Residency Agreement must be given to the resident and the resident's representative, as applicable, at the time the screening and assessment is conducted. Before the resident's admission, a signed and dated copy of the Residency Agreement must be obtained and placed in the resident's record. The policies within the Residency Agreement must be consistent with the practices of the licensee, staff, occupants, and visitors of the home. (See OAR 411-050-0615).

(9) RESIDENT MOVES AND TRANSFERS. The licensee must support a resident's choice to remain in his or her living environment, while recognizing that some residents may no longer be appropriate for the adult foster care setting due to safety and medical limitations.

(a) If a resident moves, or intends to move, out of an adult foster home for any reason, the licensee must cooperate with the potential provider's screening and assessment activities as directed by the resident or the resident's representative, and submit copies of pertinent information from the resident's record to the resident's new place of residence at the time of move. Pertinent information must include, at a minimum:

(A) Copies of current prescribing medical practitioner's orders for medications, current medication sheets, an updated care plan, including the elements of any person-centered service plan, and any documentation of limitations.

(B) Documentation of actions taken by the adult foster home staff, resident, or the resident's representative pertaining to the move or transfer.

(b) A licensee must immediately document voluntary and involuntary moves or transfers from the adult foster home in the resident's record as events take place. (See sections (10)-(13) of this rule).

(10) VOLUNTARY MOVES AND TRANSFERS.

(a) If a resident eligible for Medicaid services or the resident's representative gives notice of the resident's intent to leave the adult foster home, or the resident leaves the home abruptly, the licensee must promptly notify the resident's case manager and the local licensing authority.

(b) A licensee must obtain prior authorization from the resident, the resident's representative, and case manager, as applicable, before the resident's:

(A) Voluntary move from one bedroom to another in the adult foster home;

(B) Voluntary transfer from one adult foster home to another home that has a license issued to the same person; or

(C) Voluntary move to any other location.

(c) Notifications and authorizations of voluntary moves and transfers must be documented and available in the resident's record.

(d) The licensee remains responsible for the provision of care and services until the resident has moved from the home.

(11) INVOLUNTARY MOVES AND TRANSFERS.

(a) A resident may only be moved involuntarily to another room within the adult foster home, transferred to another adult foster home operated by the same licensee for a temporary or permanent stay, or moved from the adult foster home for the following reasons:

(A) Medical reasons. The resident has a medical or nursing condition that is complex, unstable, or unpredictable that exceeds the level of care and services the facility provides.

(B) The adult foster home is unable to accomplish evacuation of the adult foster home in accordance with OAR 411-050-0650.

(C) Welfare of the resident or other residents, including:

(i) The resident exhibits behavior that poses an imminent danger to self or others, including acts that result in the resident's arrest or detention;

(ii) The resident engages in behavior or action that repeatedly and substantially interfere with the rights, health, or safety of the residents or others; or

(iii) The resident engages in illegal drug use or commits a criminal act that causes potential harm to the resident or others.

(D) Failure to make payment for care or failure to make payment for room and board.

(E) The adult foster home has had its license revoked, not renewed, or the license was voluntarily surrendered by the licensee.

(F) The home was not notified before the resident's admission, or learns following the resident's admission, that the resident is on probation, parole, or post-prison supervision after being convicted of a sex crime defined in ORS 181.805.

(G) The licensee's Medicaid Provider Enrollment Agreement or specialized contract is terminated (pertains only to residents eligible for Medicaid).

(H) The resident engages in the use of legal medical marijuana, recreational marijuana, or both, in violation of the home's written policies or contrary to Oregon Law under ORS chapter 475B, Cannabis Regulation.

(b) MANDATORY WRITTEN NOTICE. A resident may not be moved involuntarily from the adult foster home, to another room within the adult foster home, or transferred to another adult foster home for a temporary or permanent stay without a minimum of 30 calendar days' written notice. The notice must be delivered in person to the resident and must be delivered in person or sent by registered or certified mail to the resident's representative, guardian, or conservator, and a copy must be immediately submitted to the local licensing authority, and to the resident's case manager, as applicable. Where a resident lacks capacity and there is no representative, a copy of the notice must be immediately submitted to the State Long Term Care Ombudsman. The written notice must:

(A) Be on the Department's Notice of Involuntary Move or Transfer of Resident form (SDS 901);

(B) Be completed by the licensee; and

(C) Include the following information:

(i) The resident's name;

(ii) The reason for the proposed move or transfer, including the specific reasons the facility is unable to meet the resident's needs;

(iii) The date of the proposed change;

(iv) The resident's new location, if known;

(v) A notice of the right to hold an informal conference and hearing;

(vi) The name, address, and telephone number of the person giving the notice; and

(vii) The date the notice is issued.

(c) LESS THAN 30 DAYS' WRITTEN NOTICE. A licensee may give less than 30 calendar days' written notice in specific circumstances as identified in paragraphs (A) to (C) below, but must do so as soon as possible using the Department's Notice of Involuntary Move or Transfer of Resident form (SDS 901). The notice must be given in person to the resident, the resident's representative, guardian, conservator, and a copy must be immediately submitted to the local licensing authority, and to the resident's case manager, as applicable. The reasons for the notice must be fully documented in the resident's record. The licensee remains responsible for the provision of care and services until the resident has moved from the home. A licensee may give less than 30 calendar days' notice only if:

(A) Undue delay in moving the resident would jeopardize the health, safety, or well-being of the resident, including:

(i) The resident has a medical emergency that requires the immediate care of a level or type the adult foster home is unable to provide.

(ii) The resident exhibits behavior that poses an immediate danger to self or others.

(B) The resident is hospitalized or is temporarily out of the home and the licensee determines he or she is no longer able to meet the needs of the resident; or

(C) The home was not notified before the resident's admission, or learns following the resident's admission, the resident is on probation, parole, or post-prison supervision after being convicted of a sex crime defined in ORS 181.805.

(i) In the event a resident is given notice of an involuntary move due to (11)(c)(C) of this rule, the notice may be given without reasonable advance notice.

(ii) The resident shall be given the Department's Notice of Involuntary Move or Transfer of Resident form (SDS 901) as stated in (11) of this rule.

(12) RESIDENT HEARING RIGHTS. A resident, who has been given formal notice of an involuntary move or refused the right of return or re-admission, is entitled to an informal conference and hearing before the involuntary move or transfer as follows:

(a) INFORMAL CONFERENCE. The local licensing authority must hold an informal conference as promptly as possible after the request is received. The local licensing authority must send written notice of the time and place of the conference to the licensee and all persons entitled to the notice. Participants may include the resident and at the resident's request, a family member, case manager, Ombudsman, legal representative of the resident, the licensee, and a representative from an adult foster home association or SEIU if requested by the licensee. The purpose of the informal conference is to resolve the matter without an administrative hearing. If a resolution is reached at the informal conference, the local licensing authority must document the outcome in writing and no administrative hearing is needed.

(b) ADMINISTRATIVE HEARING. If a resolution is not reached as a result of the informal conference, the resident or the resident's representative may request an administrative hearing. If the resident is being moved or transferred with less than 30 calendar days' notice according to section (11)(c) of this rule, the hearing must be held within seven business days of the move or transfer. The licensee must hold a space available for the resident pending receipt of an administrative order. These administrative rules and ORS 441.605(4) governing transfer notices and hearings for residents of long-term care facilities apply to adult foster homes.

(13) CLOSURE OF ADULT FOSTER HOMES.

(a) A licensee must notify the local licensing authority before the voluntary closure, proposed sale, or transfer of ownership of the home, and give the residents and the residents' families, representatives, and case managers, as appropriate, a minimum of 30 calendar days' written notice on the Department's form (SDS 901) according to section (11) of this rule.

(b) In circumstances where undue delay might jeopardize the health, safety, or well-being of residents, licensees, or staff, written notice must be given as soon as possible, according to section (11)(c).

(c) A licensee must surrender the physical license to operate an adult foster home to the local licensing authority at the time of the adult foster home's closure.

Stat. Auth.: ORS 410.070, 443.001, 443.004, 443.705-795, 443.880

Stats. Implemented: ORS 197.660-670, 441.373, 443.001-004, 443.705-825, 443.875, 443.991

Hist.: SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0644, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 50-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0650

Facility and Safety Standards

In order to qualify for or maintain a license, an adult foster home must comply with the following provisions:

(1) GENERAL CONDITIONS.

(a) INTERIOR AND EXTERIOR PREMISES. The building and furnishings, patios, decks, and walkways, as applicable, must be clean and in good repair. The interior and exterior premises must be well maintained and accessible according to the individual needs of the residents. There must be no accumulation of garbage, debris, rubbish, or offensive odors. Walls, ceilings, and floors must be of such character to permit washing, cleaning, or painting, as appropriate.

(b) ADDRESS. The address numbers of the adult foster home must be placed on the home in a position that is legible and clearly visible from the street or road fronting the property. If the home is so situated that the address number is not legible and clearly visible from the road fronting the property, such as when the home is accessed via a lengthy driveway or private access road, then the address numbers must also be posted where the driveway or private access road joins the fronting road. The address numbers must be at least four inches in height, made of reflective material, and contrast with the background.

(c) LIGHTING. Adequate lighting, based on the needs of the occupants, must be provided in each room, stairway, and exit way. Incandescent light bulbs and florescent tubes must be protected with appropriate covers.

(d) TEMPERATURE. The heating system must be in working order. Areas of the home used by the residents must be maintained at a comfortable temperature. Minimum temperatures during the day must be not less than 68 degrees, no greater than 85 degrees, and not less than 60 degrees during sleeping hours. Variations from the requirements of this rule must be based on resident care needs or preferences and must be addressed in each resident's care plan.

(A) During times of extreme summer heat, the licensee must make reasonable effort to keep the residents comfortable using ventilation, fans, or air conditioning. Precautions must be taken to prevent resident exposure to stale, non-circulating air.

(B) If the facility is air-conditioned, the system must be functional and the filters must be cleaned or changed as needed to ensure proper maintenance.

(C) If the licensee is unable to maintain a comfortable temperature for the residents during times of extreme summer heat, air conditioning or another cooling system may be required.

(e) COMMON USE AREAS. Common use areas for the residents must be accessible to all residents. There must be at least 150 square feet of common living space and sufficient furniture in the home to accommodate the recreational and socialization needs of all the occupants at one time.

Common space may not be located in an unfinished basement or garage unless such space was constructed for that purpose or has otherwise been legalized under permit. There may be additional space required if wheelchairs are to be accommodated. An additional 40 square feet of common living space is required for each day care individual, room and board tenant, or relative receiving care for remuneration that exceeds the limit of five.

(2) SANITATION AND PRECAUTIONS.

(a) NON-MUNICIPAL WATER SOURCE. A public water supply must be utilized if available. If a non-municipal water source is used, the licensor, a sanitarian, or a technician from a certified water-testing laboratory must collect a sample annually or as required by the Department. The water sample must be tested for coliform bacteria. Water testing and any necessary corrective action to ensure water is suitable for drinking must be completed at the licensee's expense. Water testing records must be retained for three years.

(b) Septic tanks or other non-municipal sewage disposal systems must be in good working order.

(c) COMMODES AND INCONTINENCE GARMENTS. Commodes used by residents must be emptied frequently and cleaned daily, or more frequently if necessary. Incontinence garments must be disposed of in closed containers.

(d) WATER TEMPERATURE. A resident who is unable to safely regulate the water temperature must be supervised.

(e) LAUNDRY. Before laundering, soiled linens and clothing must be stored in closed containers in an area that is separate from food storage, kitchen, and dining areas. Pre-wash attention must be given to soiled and wet bed linens. Sheets and pillowcases must be laundered at least weekly and more often if soiled.

(f) Garbage and refuse must be suitably stored in readily cleanable, rodent-proof, covered containers, pending weekly removal.

(g) VENTILATION. All doors and windows that are used for ventilation must have screens in good condition.

(h) INFECTION CONTROL. Standard precautions for infection control must be followed in resident care. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood or other body fluids.

(i) DISPOSAL OF SHARPS. Precautions must be taken to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures. The puncture-resistant container must be located as close as practical to the use area. Disposal must be made according to local regulations as stated in section (5) of this rule. (See 459.386 to 459.405).

(j) FIRST AID. Current, basic first-aid supplies and a first-aid manual must be readily available in the home.

(k) PESTS. Reasonable precautions must be taken to prevent pests (e.g., ants, cockroaches, other insects, and rodents).

(l) PETS OR OTHER ANIMALS. Sanitation for household pets and other domestic animals on the premises must be adequate to prevent health hazards. Proof of rabies vaccinations and any other vaccinations that are required for the pet by a licensed veterinarian must be maintained on the premises. Pets not confined in enclosures must be under control and not present a danger to the residents or guests.

(m) SAFETY BARRIERS. Patios, decks, walkways, swimming pools, hot tubs, spas, saunas, water features, and stairways, as appropriate, must be equipped with safety barriers designed to prevent injury. Resident access to or use of swimming or other pools, hot tubs, spas, or saunas on the premises must be supervised.

(3) BATHROOMS. Bathrooms must:

(a) Provide individual privacy and have a finished interior with a door that opens to a hall or common-use room. If a resident's bedroom includes a private bathroom, the door for the private bathroom must open to the bedroom. No person must have to walk through another person's bedroom to access a bathroom.

(b) Be large enough to accommodate the individual needs of the residents and any equipment that may be necessary.

(c) Have a mirror, a window that opens or other means of ventilation, and a window covering for privacy.

(d) Be clean and free of objectionable odors.

(e) Have bathtubs, showers, toilets, and sinks in good repair. A sink must be located near each toilet and a toilet and sink must be available for the resident's use on each floor with resident rooms. There must be at least one toilet, one sink, and one bathtub or shower for each six household occupants (including residents, day care individuals, room and board tenants, the licensee, and the licensee's family).

(f) Have hot and cold water at each bathtub, shower, and sink in sufficient supply to meet the needs of the residents.

(g) Have nonporous surfaces for shower enclosures. Glass shower doors, if applicable, must be tempered safety glass, otherwise, shower curtains must be clean and in good condition.

(h) Have non-slip floor surfaces in bathtubs and showers.

(i) Have grab bars for each toilet, bathtub, and shower to be used by the residents for safety.

(j) Have barrier-free access to toilet and bathing facilities.

(k) Have adequate supplies of toilet paper and soap supplied by the licensee. Residents must be provided with individual towels and washcloths that are laundered in hot water at least weekly or more often if necessary. Residents must have appropriate racks or hooks for drying bath linens. If individual hand towels are not provided, roller-dispensed hand towels or paper towels in a dispenser must be provided for the residents' use.

(4) BEDROOMS.

(a) Bedrooms for all household occupants must have:

(A) Been constructed as a bedroom when the home was built, or remodeled under permit.

(B) A finished interior with walls or partitions of standard construction that go from floor to ceiling.

(C) A door that opens directly to a hallway or common use room without passage through another bedroom or common bathroom. The bedroom door must be large enough to accommodate the occupant of the room and any mobility equipment that may be needed by the resident.

(D) Adequately ventilation, heating, and lighting with at least one window that opens and meets the requirements in section (5)(e) of this rule.

(E) At least 70 square feet of usable floor space for one resident or 120 square feet for two residents excluding any area where a sloped ceiling does not allow a person to stand upright.

(F) No more than two occupants per room. (See also OAR 411-050-0632 pertaining to a child's bedroom). This rule is not intended to prohibit a child five years of age or younger from occupying his or her parent's bedroom.

(b) The licensee, any other caregivers, and family members may not sleep in areas designated as living areas or share a bedroom with a resident. This rule is not intended to prohibit a caregiver or other person of the resident's choosing from temporarily staying in the resident's room when required by the resident's condition.

(c) There must be a bed at least 36 inches wide for each resident consisting of a mattress and springs, or equivalent, in good condition. Cots, rollaways, bunks, trundles, daybeds with restricted access, couches, and folding beds may not be used for residents. Each bed must have clean bedding in good condition consisting of a bedspread, mattress pad, two sheets, a pillow, a pillowcase, and blankets adequate for the weather. Waterproof mattress covers must be used for incontinent residents. Day care individuals may use a cot or rollaway bed if bedroom space is available that meets the requirements of section (4)(a) of this rule. A resident's bed may not be used by a day care individual.

(d) Each resident's bedroom must have a separate, private dresser and closet space sufficient for the resident's clothing and personal effects, including hygiene and grooming supplies. A resident must be provided a private, secure storage space to keep and use reasonable amounts of personal belongings. A licensee may not use a resident's bedroom for storage of items, supplies, devices, or appliances that do not belong to the resident.

(e) All resident bedroom doors must have a locking device on the inside of the door, released by a single action. (See OAR 411-050-0650(5)). Providers licensed before January 1, 2016 have until September 1, 2018 to fully implement this requirement.

(f) Drapes or shades for bedroom windows must be in good condition and allow privacy for the residents.

(g) A resident who is non-ambulatory, has impaired mobility, or is cognitively impaired must have a bedroom with a safe, second exit at ground level. A resident with a bedroom above or below the ground floor must demonstrate his or her capability for self-preservation.

(h) Resident bedrooms must be in close enough proximity to the licensee or caregiver in charge to alert the licensee or caregiver in charge to resident nighttime needs or emergencies, or the bedrooms must be equipped with a functional call bell or intercom within the residents' abilities to operate. Intercoms may not violate the resident's right to privacy and must have the capability of being turned off by the resident or at the resident's request.

(i) Bedrooms used by the licensee, resident manager, shift caregiver, and substitute caregiver, as applicable, must be located in the adult foster

home and must have direct access to the residents through an interior hallway or common use room.

(5) SAFETY.

(a) FIRE AND LIFE SAFETY. Buildings must meet all applicable state and local building, mechanical, and housing codes for fire and life safety. The home may be inspected for fire safety by the State Fire Marshal's Office, or the State Fire Marshal's designee, at the request of the local licensing authority or the Department using the standards in these rules, as appropriate.

(b) HEAT SOURCES. All heating equipment including, but not limited to, wood stoves, pellet stoves, and fireplaces must be installed in accordance with all applicable state and local building and mechanical codes. Heating equipment must be in good repair, used properly, and maintained according to the manufacturer's or a qualified inspector's recommendations.

(A) A licensee who does not have a permit verifying proper installation of an existing woodstove, pellet stove, or gas fireplace must have it inspected by a qualified inspector, Certified Oregon Chimney Sweep Association member, or Oregon Hearth, Patio, and Barbeque Association member and follow the inspector's recommended maintenance schedule.

(B) Fireplaces must have approved and listed protective glass screens or metal mesh screens anchored to the top and bottom of the fireplace opening.

(C) The local licensing authority may require the installation of a noncombustible, heat-resistant, safety barrier 36 inches around a woodstove to prevent residents with ambulation or confusion problems from coming in contact with the stove.

(D) Unvented, portable oil, gas, or kerosene heaters are prohibited. Sealed electric transfer heaters or electric space heaters with tip-over, shutoff capability may be used when approved by the State Fire Marshal or the State Fire Marshal's designee. A heater must be directly connected to an electrical outlet and may not be connected to an extension cord.

(c) EXTENSION CORDS AND ADAPTORS. Extension cord wiring and multi-plug adaptors may not be used in place of permanent wiring. UL-approved, re-locatable power taps (RPTs) with circuit breaker protection and no more than six electrical sockets are permitted for indoor use only and must be installed and used in accordance with the manufacturer's instructions. If RPTs are used, the RPT must be directly connected to an electrical outlet, never connected to another RPT (known as daisy-chaining or piggy-backing), and never connected to an extension cord.

(d) LOCKS AND ALARMS. Hardware for all exit doors and interior doors must be readily visible, have simple hardware that may not be locked against exit, and have an obvious method of operation. Hasps, sliding bolts, hooks and eyes, slide chain locks, and double key deadbolts are not permitted.

(A) All resident bedroom doors must have a locking device on the inside of the door, released by a single action.

(B) Each resident shall be provided a key that locks and unlocks only his or her bedroom door.

(C) A master key to all of the residents' bedroom door locks must be immediately available to the licensee and all other caregivers in the home.

(D) Providers licensed prior to January 1, 2016 must be in full compliance with (A) through (C) of this rule by September 1, 2018.

(E) If a home has a resident with impaired judgment who is known to wander away, the home must have an activated alarm system to alert a caregiver of the resident's unsupervised exit.

(e) WINDOWS. Bedrooms must have at least one window or exterior door that leads directly outside, readily opens from the inside without special tools, and provides a clear opening of not less than 821 square inches (5.7 sq. ft.), with the least dimensions not less than 24 inches in height or 20 inches in width. If the interior sill height of the window is more than 44 inches from the floor level, approved steps or other aids to the window exit that the occupants are capable of using must be provided. Windows with a clear opening of not less than 5.0 square feet or 720 square inches with interior sill heights of no more than 48 inches above the floor may be accepted when approved by the State Fire Marshal or the State Fire Marshal's designee.

(f) CONSTRUCTION. Interior and exterior doorways must be wide enough to accommodate the mobility equipment used by the residents such as wheelchairs and walkers. All interior and exterior stairways must be unobstructed, equipped with handrails on both sides, and appropriate to the condition of the residents. (See also section (5)(q) of this rule).

(A) Buildings must be of sound construction with wall and ceiling flame spread rates at least substantially comparable to wood lath and plaster or better. The maximum flame spread index of finished materials may not exceed 200 and the smoke developed index may not be greater than 450. If more than 10 percent of combined wall and ceiling areas in a sleeping room or exit way is composed of readily combustible material such as acoustical tile or wood paneling, such material must be treated with an approved flame retardant coating. Exception: Buildings supplied with an approved automatic sprinkler system.

(i) MANUFACTURED HOMES. A manufactured home (formerly mobile homes) must have been built in 1976 or later and designed for use as a home rather than a travel trailer. The manufactured home must have a manufacturer's label permanently affixed on the unit itself that states the manufactured home meets the requirements of the Department of Housing and Urban Development (HUD). The required label must read as follows:

"As evidenced by this label No. ABC000001, the manufacturer certifies to the best of the manufacturer's knowledge and belief that this mobile home has been inspected in accordance with the requirements of the Department of Housing and Urban Development and is constructed in conformance with the Federal Mobile Home Construction and Safety Standards in effect on the date of manufacture. See date plate."

(ii) If such a label is not evident and the licensee believes the manufactured home meets the required specifications, the licensee must take the necessary steps to secure and provide verification of compliance from the home's manufacturer.

(iii) Manufactured homes built in 1976 or later meet the flame spread rate requirements and do not have to have paneling treated with a flame retardant coating.

(B) STRUCTURAL CHANGES. The licensee must notify the local licensing authority, in writing, at least 15 calendar days before any remodeling, renovations, or structural changes in the home that require a building permit. Such activity must comply with local building, sanitation, utility, and fire code requirements applicable to a single-family dwelling (see ORS 443.760(1)). The licensee must forward all required permits and inspections, an evacuation plan as described in section (5)(l) of this rule, and a revised floor plan as described in section (5)(o) of this rule, to the local licensing authority within 30 calendar days of completion.

(g) FIRE EXTINGUISHERS. At least one fire extinguisher with a minimum classification of 2-A:10-B:C must be mounted in a location visible and readily accessible to any occupant of the home on each floor, including basements. Fire extinguishers must be checked at least once a year by a qualified person who is well versed in fire extinguisher maintenance. All recharging and hydrostatic testing must be completed by a qualified agency properly trained and equipped for this purpose.

(h) CARBON MONOXIDE AND SMOKE ALARMS.

(A) CARBON MONOXIDE ALARMS. Carbon monoxide alarms must be listed as complying with ANSI/UL 2034 and must be installed and maintained in accordance with the manufacturer's instructions. Carbon monoxide alarms must be installed within 15 feet of each bedroom at the height recommended by the manufacturer.

(i) If bedrooms are located in multi-level homes, carbon monoxide alarms must be installed on each level, including the basement.

(ii) Carbon monoxide alarms may be hard-wired, plug-in, or battery operated. Hard wired and plug-in alarms must be equipped with a battery back-up. Battery operated carbon monoxide alarms must be equipped with a device that warns of a low battery.

(iii) A bedroom used by a hearing-impaired occupant who may not hear the sound of a regular carbon monoxide alarm must be equipped with an additional carbon monoxide alarm that has visual or vibrating capacity.

(B) SMOKE ALARMS. Smoke alarms must be installed in accordance with the manufacturer's instructions in each bedroom, in hallways or access areas that adjoin bedrooms, the family room or main living area where occupants congregate, any interior designated smoking area, and in basements. In addition, smoke alarms must be installed at the top of all stairways in multi-level homes.

(i) Ceiling placement of smoke alarms is recommended.

(ii) Battery operated smoke alarms or hard-wired smoke alarms with a battery backup must be equipped with a device that warns of a low battery.

(iii) A bedroom used by a hearing-impaired occupant who may not hear the sound of a regular smoke alarm must be equipped with an additional smoke alarm that has visual or vibrating capacity.

(C) All carbon monoxide alarms and smoke alarms must contain a sounding device or be interconnected to other alarms to provide, when activated an alarm that is audible in all sleeping rooms. The alarms must be loud enough to wake occupants when all bedroom doors are closed. Intercoms and room monitors may not be used to amplify alarms.

(D) The licensee must test all carbon monoxide alarms and smoke alarms in accordance with the manufacturer's instructions at least monthly (per NFPA 72). Testing must be documented in the facility records. The licensee must maintain carbon monoxide alarms, smoke alarms, and fire extinguishers in functional condition. If there are more than two violations in maintaining battery operated alarms in working condition, the Department may require the licensee to hard wire the alarms into the electrical system.

(i) COMBUSTIBLES AND FIREARMS. Flammables, combustible liquids, and other combustible materials must be safely and properly stored in the original, properly labeled containers or safety containers and secured in areas to prevent tampering by residents or vandals.

(A) Oxygen and other gas cylinders in service or in storage, must be adequately secured to prevent the cylinders from falling or being knocked over.

(B) No smoking signs must be visibly posted where oxygen cylinders are present.

(C) Firearms must be stored, unloaded, in a locked cabinet. The firearms cabinet must be located in an area of the home that is not accessible to the residents.

(D) Ammunition must be secured in a locked area separate from the firearms.

(j) HAZARDOUS MATERIALS. Cleaning supplies, poisons, insecticides, and other hazardous materials must be properly stored in the original container, or in a container manufactured for the type of product. The containers must be properly labeled and kept in a safe area that is not accessible to residents, or near food preparation areas, food storage areas, dining areas, or medications.

(k) MEDICAL SHARPS. All sharps, including, but not limited to needles and lancets, must be disposed of in approved sharps containers. Sharps containers must:

(A) Be puncture-resistant;

(B) Be leak-proof;

(C) Be labeled or color-coded red to warn that the contents are hazardous;

(D) Have a lid, flap, door, or other means of closing the container and inhibits the ability to remove sharps from the container;

(E) Not be overfilled;

(F) Be stored in an upright position in a secure location that is not accessible to residents and not close to any food preparation or food storage area; and

(G) Must be closed immediately once full and properly disposed of within 10 days, according to the home's waste management company's or pharmacy's instructions.

(l) EVACUATION PLAN. An emergency evacuation plan must be developed and revised as necessary to reflect the current condition of the residents in the home. The evacuation plan must be rehearsed with all occupants.

(m) ORIENTATION TO EMERGENCY PROCEDURES. Within 24 hours of arrival, any new resident or caregiver must be shown how to respond to a smoke alarm, shown how to participate in an emergency evacuation drill, and receive an orientation to basic fire safety. New caregivers must also be oriented in how to conduct an evacuation.

(n) EVACUATION DRILL. An evacuation drill must be held at least once every 90 calendar days, with at least one evacuation drill per year conducted during sleeping hours. The evacuation drill must be clearly documented, signed by the caregiver conducting the drill, and maintained according to OAR 411-050-0645.

(A) The licensee and all other caregivers must:

(i) Be able to demonstrate the ability to evacuate all occupants from the facility to the initial point of safety within three minutes or less. The initial point of safety must:

(I) Be exterior to and a minimum of 25 feet away from the structure;

(II) Have direct access to a public sidewalk or street; and

(III) Not be in the backyard of a home unless the backyard has direct access to a public street or sidewalk.

(ii) Be able to demonstrate the ability to further evacuate all occupants from the initial point of safety to the final point of safety within two minutes or less. The final point of safety must be a minimum of 50 feet away from the structure, and:

(I) Have direct access to a public sidewalk or street; or

(II) Not be in the backyard of a home unless the backyard has direct access to a public street or sidewalk.

(B) Conditions may be applied to a license if the licensee or caregivers demonstrate the inability to meet the evacuation times described in this section. Conditions may include, but are not limited to, reduced capacity of residents, additional staffing, or increased fire protection. Continued problems are grounds for revocation or non-renewal of the license.

(o) FLOOR PLAN. The licensee must develop a current and accurate floor plan that indicates:

(A) The size of rooms;

(B) Which bedrooms are to be used by residents, the licensee, caregivers, and for day care and room and board tenants, as applicable;

(C) The location of all the exits on each level of the home, including emergency exits such as windows;

(D) The location of wheelchair ramps;

(E) The location of all fire extinguishers, smoke alarms, and carbon monoxide alarms;

(F) The planned evacuation routes, initial point of safety, and final point of safety; and

(G) Any designated smoking areas in or on the adult foster home's premises.

(p) RESIDENT PLACEMENT. A resident, who is unable to walk without assistance or not capable of self-preservation, may not be placed in a bedroom on a floor without a second ground level exit. (See also section (4)(g) of this rule).

(q) STAIRS. Stairs must have a riser height of between 6 to 8 inches and tread width of between 8 to 10.5 inches. Lifts or elevators are not an acceptable substitute for a resident's capability to ambulate stairs. (See also section (5)(f) of this rule).

(r) EXIT WAYS. All exit ways must be barrier free and the corridors and hallways must be a minimum of 36 inches wide or as approved by the State Fire Marshal or the State Fire Marshal's designee. Interior doorways used by the residents must be wide enough to accommodate residents' wheelchairs and walkers, and beds that are used by residents for evacuation purposes. Any bedroom window or door identified as an exit must remain free of obstacles that would interfere with evacuation.

(s) RAMPS. There must be at least one wheelchair ramp from a minimum of one exterior door if an occupant of the home is non-ambulatory. Wheelchair ramps must comply with the U.S. Department of Justice's 2010 Americans with Disabilities Act (ADA) Standards for Accessible Design (http://www.ada.gov/2010ADAstandards_index.htm, Chapter 4, Accessible Routes, Section 405, Ramps).

(t) EMERGENCY EXITS. There must be a second safe means of exit from all sleeping rooms. A provider whose sleeping room is above the first floor may be required to demonstrate at the time of licensure, renewal, or inspection, how the premises will be evacuated from the provider's sleeping room using the secondary exit.

(u) FLASHLIGHT. There must be at least one plug-in, rechargeable flashlight in good functional condition available on each floor of the home for emergency lighting.

(v) SMOKING. The licensee must identify the home's smoking policies in the home's Residency Agreement. If smoking is allowed in or on the premises of the home:

(A) The Residency Agreement must restrict smoking to designated areas, and prohibit smoking in:

(i) Any bedroom, including that of the residents, licensee, resident manager, any other caregiver, occupant, or visitor;

(ii) Any room where oxygen is used; and

(iii) Anywhere flammable materials are stored.

(B) Ashtrays of noncombustible material and safe design must be provided in areas where smoking is permitted.

(w) EMERGENCY PREPAREDNESS PLAN. A licensee must develop and maintain a written emergency preparedness plan for the protection of all occupants in the home in the event of an emergency or disaster. Emergency supplies, consistent with the community standards (as indicated at: www.redcross.org/prepare/location/home-family) must be kept current and readily available in the home.

(A) The written emergency plan must:

(i) Include an evaluation of potential emergency hazards including, but not limited to:

(I) Prolonged power failure or water or sewer loss;

(II) Fire, smoke, or explosion;

(III) Structural damage;

(IV) Hurricane, tornado, tsunami, volcanic eruption, flood, or earthquake;

(V) Chemical spill or leak; and

(VI) Pandemic.

(ii) Include an outline of the caregiver's duties during an evacuation.

(iii) Consider the needs of all occupants of the home including, but not limited to:

(I) Access to medical records necessary to provide services and treatment.

(II) Access to pharmaceuticals, medical supplies, and equipment during and after an evacuation.

(III) Behavioral support needs.

(iv) Include provisions and supplies sufficient to shelter in place for a minimum of three days without electricity, running water, or replacement staff.

(v) Planned relocation sites.

(B) The licensee must notify the Department or the local licensing authority of the home's status in the event of an emergency that requires evacuation and during any emergent situation when requested.

(C) The licensee must re-evaluate the emergency preparedness plan at least annually and whenever there is a significant change in the home.

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

Stats. Implemented: ORS 443.001-004, 443.705-825, 443.875, 443.991

Hist.: SSD 14-1985, f. 12-31-85 ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88, Sections (8) thru (10) renumbered to 411-050-0447; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 2-1998(Temp), f. & cert. ef. 2-6-98 thru 8-1-98; SDSD 6-1998, f. 7-31-98, cert. ef. 8-1-98; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 9-2007, f. 6-27-07, cert. ef. 7-1-07; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0445, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0655

Standards and Practices for Care and Services

(1) PRE-ADMISSION SCREENING AND ASSESSMENT.

(a) Before admission, the licensee must conduct and document a screening to determine if a prospective resident's care needs exceed the license classification of the home. The screening must:

(A) Evaluate the ability of the prospective resident to evacuate the home within three minutes along with all the occupants of the home.

(B) Determine if the licensee and caregivers are able to meet the prospective resident's needs in addition to meeting the needs of the other residents of the home.

(C) Include medical diagnoses, medications, personal care needs, nursing care needs, cognitive needs, communication needs, night care needs, nutritional needs, activities, lifestyle preferences, and other information, as needed, to assure the prospective resident's care needs shall be met.

(b) The screening process must include interviews with the prospective resident and the prospective resident's family, prior care providers, and case manager, as appropriate. The licensee must also interview, as necessary, any physician, nurse practitioner, physician assistant, registered nurse, pharmacist, therapist, or mental health or other licensed health care professional involved in the care of the prospective resident. A copy of the screening document must be:

(A) Given to the prospective resident or the prospective resident's representative.

(B) Placed in the resident's record if admitted to the home; or

(C) Maintained for a minimum of three years if the prospective resident is not admitted to the home.

(c) If the Department or AAA knows a person who is on probation, parole, or post-prison supervision after being convicted of a sex crime as defined in ORS 181.805 is applying for admission to an adult foster home, the Department or AAA shall notify the home of the person's status as a sex offender.

(d) The licensee may refuse to admit a person who is on probation, parole, or post-prison supervision after being convicted of a sex crime as defined in ORS 181.805.

(e) REQUIRED DISCLOSURES.

(A) The licensee must disclose the home's policies to a prospective resident or the prospective resident's representative, as applicable. A copy of the home's current and approved Residency Agreement identifying the home's policies shall be provided to the prospective resident and his or her representative. (See OAR 411-050-0615).

(B) LONG-TERM CARE ASSESSMENT. The licensee must inform a prospective private-pay resident or the prospective resident's representative, if appropriate, of the availability of long-term care assessment services provided through the Department or a certified assessment program. The licensee must document on the Department's form (SDS 913) that the prospective private-pay resident has been advised of the right to receive a long-term care assessment. The licensee must maintain a copy of the form in the resident's record upon admission and make a copy available to the Department upon request.

(2) BEFORE ADMISSION.

(a) The licensee must obtain and document general information regarding a resident before the resident's admission. The information must include the names, addresses, and telephone numbers of the resident's relatives, significant persons, case managers, and medical or mental health providers. The information must also include the date of admission and, if available, the resident's medical insurance information, birth date, prior living facility, and mortuary.

(b) Before admission, the licensee must obtain and place in the resident's record:

(A) Prescribing practitioner's written or verbal orders for medications, treatments, therapies, and special diets, as applicable. Any verbal orders must be followed by written orders within seven calendar days of the resident's admission. Attempts to obtain written orders must be documented in the resident's record.

(B) Prescribing practitioner or pharmacist review of the resident's preferences for over-the-counter medications and home remedies.

(C) Any medical information available, including the resident's history of accidents, illnesses, impairments, or mental status that may be pertinent to the resident's care.

(c) The licensee must ask for copies of the resident's Advance Directive, Physician's Order for Life Sustaining Treatment (POLST), and proof of court-appointed guardianship or conservatorship, if applicable. Copies of these documents must be placed in a prominent place in the resident's record and sent with the resident if the resident is transferred for medical care.

(d) The licensee must review the home's current Residency Agreement with the resident and the resident's representative, as appropriate. These reviews must be documented by having the resident, or the resident's representative, sign and date a copy of the Residency Agreement. A copy of the signed and dated Residency Agreement must be maintained in the resident's record.

(3) SCREENING BEFORE RE-ADMISSION. When a resident temporarily leaves the home including, but not limited to, a resident's hospitalization, the licensee shall conduct the necessary elements of the pre-admission and screening assessment requirements, and document those findings to:

(a) Determine whether readmission to the home is appropriate for the classification of the home.

(b) Determine whether the licensee can continue to meet the resident's care and safety needs in addition to those of the other residents.

(c) Demonstrate compliance with these rules.

(d) If applicable, demonstrate the basis for refusing the resident's readmission to the home according to OAR 411-050-0645(11).

(4) CARE PLAN.

(a) During the initial 14 calendar days following the resident's admission to the home, the licensee must continue to assess and document the resident's preferences and care needs. The assessment and care plan must be completed by the licensee and documented within the initial 14-day period. The care plan must describe the resident's needs, preferences, capabilities, what assistance the resident requires for various tasks, and must include:

(A) By whom, when, and how often care and services shall be provided;

(B) The resident's ability to perform activities of daily living (ADLs);

(C) Special equipment needs;

(D) Communication needs (examples may include, but are not limited to, hearing or vision needs, such as eraser boards or flash cards, or language barriers, such as sign language or non-English speaking);

(E) Night needs;

(F) Medical or physical health problems, including physical disabilities, relevant to care and services;

(G) Cognitive, emotional, or other impairments relevant to care and services;

(H) Treatments, procedures, or therapies;

(I) Registered nurse consultation, teaching, delegation, or assessment;

(J) Behavioral interventions;

(K) Social, spiritual, and emotional needs, including lifestyle preferences, activities, and significant others involved;

(L) The ability to exit in an emergency, including assistance and equipment needed;

(M) Any use of physical restraints or psychoactive medications; and

(N) Dietary needs and preferences.

(b) Effective January 1, 2017 and no later than February 28, 2018, the licensee must identify any individually-based limitations to the following freedoms on the Department's Individual Consent to HCBS Limitations form:

(A) Support to access to food at any time;

(B) Visitors of the resident's choosing at any time;

(C) A lock on the resident's bedroom, lockable by the resident;

(D) Choice of a roommate, if sharing a bedroom;

(E) Support to furnish and decorate the resident's bedroom as the resident chooses;

(F) Freedom and support to control the resident's schedule and activities; and

(G) Privacy in the resident's bedroom.

(c) Effective January 1, 2017 and no later than February 28, 2018, a limitation to any freedom in (b) of this rule must be supported by a specific assessed need due to threats to the health and safety of the resident or others. For Medicaid-eligible residents, the person-centered service plan coordinator must authorize the limitation and the individual must consent to the limitation. The licensee must incorporate and document all applicable elements identified in OAR 411-004-0040, including:

(A) The specific and individualized assessed need justifying the limitation.

(B) The positive interventions and supports used before any limitation.

(C) Less intrusive methods that have been tried, but did not work.

(D) A clear description of the condition that is directly proportionate to the specific assessed need.

(E) Regular reassessment and review to measure the ongoing effectiveness of the limitation.

(F) Established time limits for periodic review of the limitation to determine if the limitation should be terminated or remains necessary. The limitation must be reviewed at least annually.

(G) The informed consent of the resident or, as applicable, the legal representative of the resident, including any discrepancy between the wishes of the resident and the consent of the legal representative.

(H) An assurance that the interventions and support do not cause harm to the individual.

(d) Limitations are not transferable between care settings. Continued need for any limitation at the new care setting must comply with the requirements as stated in OAR 411-050-0655.

(e) The licensee must review and update each resident's care plan every six months and when a resident's condition changes. The review must be documented in the resident's record at the time of the review and include the date of the review and the licensee's signature. If a care plan contains many changes and becomes less legible, a new care plan must be written.

(5) PERSON-CENTERED SERVICE PLAN. A Medicaid-eligible resident's case manager will complete a person-centered service plan, pursuant to OAR 411-004-0030. The licensee must incorporate all applicable elements identified in the person-centered service plan that the provider is responsible for implementing.

(a) The licensee must notify the resident's case manager in the event a review and change or removal of an existing limitation is warranted, and when a new limitation is supported by a specific assessed need.

(A) All attempts to notify the resident's case manager about a review to change, remove, or add a limitation must be documented, and available in the resident's record.

(B) The licensee will not be held responsible for any failure on the case manager's part to conduct a review of current limitations or to complete the person-centered service plan.

(b) Providers may assist non-Medicaid residents in developing a person-centered service plan when no alternative resources are available.

(6) REGISTERED NURSE CONSULTATION.

(a) RN CONSULTATION AND ASSESSMENT. A licensee must obtain a medical professional consultation and assessment to meet the care needs of a resident as required in these rules. A registered nurse consultation must be obtained when a skilled nursing care task, as defined by the Oregon State Board of Nursing, has been ordered by a physician or other licensed health care professional.

(b) A licensee must also request a registered nurse consultation under the following conditions:

(A) When a resident has a health concern or behavioral symptoms that may benefit from a nursing assessment and provider education.

(B) When written parameters are needed to clarify a prescribing practitioner p.r.n. order for medication and treatment (See section (7)(g) of this rule).

(C) Before the use of physical restraints when not assessed, taught, and reassessed, according to section (7)(o) of this rule, by a physician, nurse practitioner, physician assistant, Christian Science practitioner, mental health clinician, physical therapist, or occupational therapist.

(D) Before requesting psychoactive medications to treat behavioral symptoms or the use of new psychoactive medications when not assessed, taught, and reassessed according to section (7)(h) of this rule, by a physician, nurse practitioner, physician assistant, or mental health practitioner.

(E) When care procedures are ordered that are new for a resident, the licensee, or other caregivers.

(c) RN DELEGATIONS. A registered nurse may determine a nursing care task be taught utilizing the delegation process. RN delegations are not transferable to other residents or caregivers. (Refer to OAR chapter 851, division 047).

(d) Documentation of nurse consultations, delegations, assessments, and reassessments must be maintained in the resident's record and made available to the Department upon request.

(7) STANDARDS FOR MEDICATIONS, TREATMENTS, AND THERAPIES.

(a) MEDICATIONS. The licensee and caregivers must demonstrate an understanding of each resident's medication administration regimen. Medication resource material must be readily available at the home and include the reason a medication is used, any specific instructions, the medication's actions, and common side effects.

(b) WRITTEN ORDERS. The licensee must obtain and place a signed order in the resident's record for any medications, dietary supplements, treatments, or therapies that have been ordered by a prescribing practitioner. The written orders must be carried out as prescribed unless the resident or the resident's legal representative refuses to consent. The prescribing practitioner must be notified if the resident refuses to consent to an order.

(A) CHANGED ORDERS. Changes to a written order may not be made without a prescribing practitioner order. The prescribing practitioner must be notified if the resident refuses to consent to the change order. Changes to medical orders obtained by telephone must be followed-up with signed orders within seven calendar days. Changes in the dosage or frequency of an existing medication require a new properly labeled and dispensed medication container. If a new properly labeled and dispensed medication container is not obtained, the change must be written on an auxiliary label attached to the medication container, not to deface the existing original pharmacy label, and must match the new medication order. Attachment of the auxiliary label must be documented in the residents' record. (See section (7)(f)(D) of this rule).

(B) DOCUMENTATION OF CHANGED ORDERS. Attempts to obtain the signed written changes must be documented and readily available for review in the resident's record. The resident's medications, including medications that are prescribed, over-the-counter medications, and home remedies, must be reviewed by the resident's prescribing practitioner or pharmacist at least annually. The review must be in writing, include the date of the review, and contain the signature of the prescribing practitioner or a pharmacist.

(c) MEDICATION SUPPLIES. The licensee must have all currently prescribed medications, including p.r.n. medications, and all prescribed over-the-counter medications available in the home for administration. Refills must be obtained before depletion of current medication supplies. Attempts to order refills must be documented in the resident's record.

(d) HEALTH CARE PROFESSIONAL ORDERS (IMPLEMENTED BY AFH STAFF). The licensee who implements a hospice, home health, or other licensed medical professional-generated order must:

(A) Have a copy of the hospice, home health, or licensed medical professional document that communicates the written order.

(B) Transcribe the order onto the medication administration record (MAR).

(C) Implement the order as written.

(D) Include the order on subsequent medical visit reports for the prescribing practitioner to review.

(e) HOSPICE AND HOME HEALTH ORDERS (IMPLEMENTED BY NON-AFH STAFF). A licensee must allow a resident to receive hospice services. The licensee who provides adult foster home services to a recipient of hospice or home health services, but who does not implement a hospice or home health-generated order must:

(A) Have a copy of the hospice or home health document that communicates the written order; and

(B) Include the order on subsequent medical visit reports for the prescribing practitioner to review.

(f) MEDICATION ADMINISTRATION RECORD (MAR). A current, written medication administration record (MAR) must be kept for each resident and must:

(A) List the name of all medications administered by a caregiver, including over-the-counter medications and prescribed dietary supplements. The MAR must identify the dosage, route, date, and time each medication and supplement is to be given.

(B) Identify any treatments and therapies administered by a caregiver. The MAR must indicate the type of treatment or therapy and the time the procedure must be performed.

(C) Be immediately initialed by the caregiver administering the medication, treatment, or therapy as it is completed. A resident's MAR must contain a legible signature that identifies each set of initials.

(D) Document changed and discontinued orders immediately showing the date of the change or discontinued order. A changed order must be written on a new line with a line drawn to the start date and time.

(E) Document missed or refused medications, treatments, or therapies. If a medication, treatment, or therapy is missed or refused by the resident, the initials of the caregiver administering the medication, treatment, or therapy must be circled, and a brief, but complete, explanation must be recorded on the back of the MAR.

(g) P.R.N. MEDICATIONS. Prescription medications ordered to be given "as needed" or "p.r.n." must have specific parameters indicating what the medication is for and specifically when, how much, and how often the medication may be administered. Any additional instructions must be available for the caregiver to review before the medication is administered to the resident.

(A) P.R.N. DOCUMENTATION. As needed (p.r.n) medications must be documented on the resident's MAR with the time, dose, the reason the medication was given, and the outcome.

(B) P.R.N. ADVANCE SET-UP. As needed (p.r.n.) medications may not be included in any advance set-up of medication.

(h) PSYCHOACTIVE MEDICATIONS.

(A) A licensee is not required to request an evaluation of a resident's use of a psychoactive medication if the resident is admitted to the home and the resident has been prescribed the psychoactive medication for a condition that is currently monitored by a physician, nurse practitioner, physician assistant, or mental health professional and the written order for the psychoactive medication is in the resident's record.

(B) If a resident is admitted to a home with no documented history as to the reason for taking a psychoactive medication, or if the licensee requests medical professional intervention to address behavioral symptoms, the licensee must request a physician, nurse practitioner, physician assistant, or mental health professional evaluate the resident's need for the psychoactive medication and the intended effect of the medication, common side effects, and circumstances for reporting. The evaluation request must be documented in the resident's record and include:

(i) A probable cause of the resident's behavior.

(ii) Behavioral and environmental interventions to be used instead of or in addition to psychoactive medication, if applicable. Alternative interventions must be tried as instructed by a licensed medical professional and the resident's response to the alternative interventions must be documented in the resident's record before administering a psychoactive medication.

(iii) A plan for reassessment by the resident's prescribing physician, nurse practitioner, physician assistant, or mental health professional.

(C) The prescription and order for a psychoactive medication must specify the dose, frequency of administration, and the circumstance for use (i.e., specific symptoms). The licensee and all caregivers must be aware of and comply with these parameters.

(D) The licensee and all caregivers must know the intended effect of a psychoactive medication for a particular resident and the common side effects, as well as the circumstances for reporting to the resident's physician, nurse practitioner, physician assistant, or mental health professional.

(E) The resident's care plan must identify and describe the behavioral symptoms psychoactive medications are prescribed for and a list of all interventions, including behavioral, environmental, and medication.

(F) Psychoactive medications must never be given to discipline a resident or for the convenience of the caregivers.

(i) MEDICATION CONTAINERS AND STORAGE.

(A) MEDICATION CONTAINERS. Each of the resident's prescribed medication containers, including bubble packs, must be clearly labeled by the pharmacy. All medications, including over-the-counter medications, must be in the original container. Medications stored in advanced set up containers are required to be labeled as described in these rules.

(B) OVER-THE-COUNTER PRODUCTS. Over-the-counter products such as medications, vitamins, and supplements purchased for a specific resident's use must be marked with the resident's name. Over-the-counter items in stock bottles (with original labels) may be used for multiple residents in the home and must be clearly marked as the house supply.

(C) STORAGE OF RESIDENT MEDICATION. All resident medications, including over-the-counter medications, must be kept in a locked, central location that is cool, clean, dry, not subject to direct sunlight, and separate from medications belonging to the licensee, caregivers, and all other non-residents. Medications requiring refrigeration must also be locked and stored separately from non-resident medications.

(D) STORAGE OF NON-RESIDENT MEDICATION. All non-resident medications must be kept locked and separate from resident medications. Residents shall not have access to medications belonging to the licensee, caregivers, other household members, or pets.

(j) DISPOSAL OF MEDICATION. Outdated, discontinued, recalled, or contaminated medications, including over-the-counter medications, may not be kept in the home and must be disposed of within 10 calendar days of expiration, discontinuation, or the licensee's knowledge of a recall or contamination. A licensee must contact the local DEQ waste management company in the home's area for instructions on proper disposal of unused or expired medications.

(k) DOCUMENTATION OF DISPOSAL. The disposal of a resident's medication must be documented in the resident's record and the documentation must be readily available in the resident's record.

(A) The disposal of a controlled substance must be documented in the resident's record and the disposal must be witnessed by a caregiver who is 18 years of age or older.

(B) Documentation regarding the disposal of medications and controlled substances must include:

(i) The date of disposal.

(ii) Description of the medication, (i.e., name, dosage, and amount being disposed).

(iii) Name of the resident for whom the medication was prescribed.

(iv) Reason for disposal.

(v) Method of disposal.

(vi) Signature of the person disposing of the medication.

(vii) For controlled substances, the signature of the caregiver who witnessed the disposal according to this rule.

(l) ADVANCED SET-UP. The licensee may set-up each resident's medications for up to seven calendar days in advance (excluding p.r.n. medications) by using a closed container manufactured for the advanced set-up of medications. If used, each resident must have his or her own container with divisions for the days of the week and times of the day the medications are to be given. The container must be clearly labeled with the resident's name, name of each medication, time to be given, dosage, amount, route, and description of each medication. The container must be stored in the locked area with the residents' medications.

(m) SELF-ADMINISTRATION OF MEDICATION. A licensee must have a prescribing practitioner written order of approval for a resident to self-medicate. A resident able to handle his or her own medical regimen may keep his or her medications in his or her own room in a lockable storage area or device. Medications must be kept locked except those medications on the residents' own person. The licensee must notify the prescriber of the medication if the resident shows signs of no longer being able to self-medicate safely.

(n) INJECTIONS. Subcutaneous, intramuscular, and intravenous injections may be self-administered by a resident if the resident is fully independent in the task or may be administered by a relative of the resident or an Oregon licensed registered nurse (RN). An Oregon licensed practical nurse (LPN) may give subcutaneous and intramuscular injections. A caregiver who has been delegated and trained by a registered nurse under provision of the Oregon State Board of Nursing (OAR 851-047-0000 to 851-047-0040) may give subcutaneous injections. Intramuscular and intravenous injections may not be delegated. (See OAR 411-050-0650(5) for storage and disposal requirements of sharps, including, but not limited to used needles and lancets).

(o) PHYSICAL RESTRAINTS. Physical restraints may only be used when required to treat a resident's medical symptoms or to maximize a resident's physical functioning. Physical restraints may only be used after a written assessment is completed as described below and all alternatives have been exhausted. Licensees and caregivers may use physical restraints in adult foster homes only in compliance with these rules, including the Resident's Rights listed in section (9) of this rule. Before the use of any type of physical restraint, the following must be completed:

(A) ASSESSMENT. A written assessment must be obtained from the resident's physician, nurse practitioner, physician assistant, registered nurse, Christian Science practitioner, mental health clinician, physical therapist, or occupational therapist that includes consideration of all other alternatives.

(B) ORDERS. If it is determined that a physical restraint is necessary following the assessment and trial of other measures, the least restrictive restraint must be used as infrequently as possible. The licensee must obtain a written order from the resident's physician, nurse practitioner, physician assistant, or Christian Science practitioner before the use of a physical restraint. The written order must include specific parameters, including the type of physical restraint, circumstances for use, and duration of use, including:

(i) Procedural guidance for the use of the physical restraint.

(ii) The frequency for reassessment.

(iii) The frequency and procedures for nighttime use.

(iv) Dangers and precautions for using the physical restraint.

(C) Physical restraints may not be used on an as needed (p.r.n.) basis in an adult foster home.

(D) CONSENT. Physical restraints must not be used without first obtaining the written consent of the resident or the resident's legal representative.

(E) DOCUMENTATION. If it is determined a physical restraint is necessary following the assessment and trial of other measures, the written order for the use of a physical restraint must be documented in the resident's care plan explaining why and when the restraint is to be used, along with instructions for periodic release. Any less restrictive, alternative measures planned during the assessment, and cautions for maintaining the resident's safety while restrained, must also be recorded in the resident's care plan. The resident's record must include:

(i) The completed assessment as described in this rule.

(ii) The written order authorizing the use of the physical restraint from the resident's physician, nurse practitioner, physician assistant, or Christian Science practitioner.

(iii) Written consent of the resident or the resident's legal representative to use the specific type of physical restraint.

(iv) The reassessments completed by a medical professional as described above in subsection (B) of this rule.

(F) DAYTIME USE. A resident physically restrained during waking hours must have the restraints released at least every two hours for a minimum of 10 minutes and be repositioned, offered toileting, and provided exercise or range-of-motion exercises during this period. The use of restraints, restraint release, and activities that occurred during the release period must be documented in the resident's record.

(G) NIGHTTIME USE. The use of physical restraints at night is discouraged and must be limited to unusual circumstances. If used, the restraint must be of a design to allow freedom of movement with safety. The frequency of night monitoring to address resident safety and care needs must be determined in the assessment. Tie restraints of any kind must not be used to keep a resident in bed.

(H) If any physical restraints are used in an adult foster home, the restraints must allow for quick release at all times. Use of restraints may not impede the three-minute evacuation of all occupants of the home.

(I) Physical restraints may not be used for the discipline of a resident or for the convenience of the adult foster home.

(8) RESIDENT CARE.

(a) Care and supervision of residents must be in a home-like atmosphere. The training of the licensee and caregivers and care and supervision of residents must be appropriate to the age, care needs, and conditions of the residents in the home. Additional staff may be required if, for example, day care individuals are in the home or if necessary to safely evacuate the residents and all occupants from the home as required by OAR 411-050-0650.

(b) If a resident has a medical regimen or personal care plan prescribed by a licensed health care professional, the provider must cooperate with the plan and ensure the plan is implemented as instructed.

(c) NOTIFICATION. The licensee must notify emergency personnel, the resident's physician, nurse practitioner, physician assistant, registered nurse, family representative, and case manager, as applicable, under the following circumstances:

(A) EMERGENCIES (MEDICAL, FIRE, POLICE). In the event of an emergency, the licensee or caregiver with the resident at the time of the emergency must first call 911 or the appropriate emergency number for the home's community. This does not apply to a resident with a medical emergency who practices Christian Science.

(i) If a resident is receiving hospice services, the caregivers must follow the written instructions for medical emergencies from the hospice nurse.

(ii) If a resident has a completed Physician's Orders for Life-Sustaining Treatment (POLST) or other legal documents, such as an Advance Directive or Do Not Resuscitate (DNR) order, copies of the documents must be made available to the emergency personnel when they arrive.

(B) HOSPITALIZATION. In the event the resident is hospitalized.

(C) HEALTH STATUS CHANGE. When the resident's health status or physical condition changes.

(D) DEATH. Upon the death of the resident.

(d) The licensee shall not inflict, or tolerate to be inflicted, abuse or punishment, financial exploitation, or neglect of the residents.

(e) The licensee must exercise reasonable precautions against any conditions that may threaten the health, safety, or welfare of the residents.

(f) A qualified caregiver must always be present and available at the home when a resident is in the home. A resident may not be left in charge in lieu of a caregiver.

(g) ACTIVITIES. The licensee must make available at least six hours of activities per week that are of interest to the residents, not including television and movies. Information regarding activity resources is available from the local licensing authority. Activities must be oriented to individual preferences as indicated in the resident's care plan. (See section (4) of this rule). Documentation of the activities offered to each resident and the resident's participation in those activities must be recorded in the resident's records.

(h) DAY CARE. Before the admission of each day care individual, the licensee must:

(A) Conduct and document a screening as described in section (1) of this rule.

(B) Obtain current medical professional orders as described in section (7) of this rule, if medications are to be administered and the necessary delegations, as applicable.

(C) Develop and maintain a current, written medication administration record (MAR) as described in section (7) of this rule, if medications are to be administered.

(i) DIRECT INVOLVEMENT OF CAREGIVERS. The licensee or caregivers must be directly involved with the residents on a daily basis. If the physical characteristics of the adult foster home do not encourage contact between the caregivers and residents and among residents, the licensee must demonstrate how regular positive contact occurs.

(j) RESIDENT MONEY. If the licensee manages or handles a resident's money, a separate account record must be maintained in the resident's name. The licensee may not under any circumstances commingle, borrow from, or pledge any of a resident's funds. The licensee may not act as a resident's guardian, conservator, trustee, or attorney-in-fact unless related by birth, marriage, or adoption to the resident as follows: parent, child, brother, sister, grandparent, grandchild, aunt, uncle, niece, or nephew. Nothing in this rule may be construed to prevent the licensee or the licensee's employee from acting as a representative payee for the resident. (See also OAR 411-020-0002 and ORS 127.520).

(A) Personal incidental funds (PIF) for individuals eligible for Medicaid services must be used at the discretion of the individual for such things as clothing, tobacco, and snacks (not part of daily diet).

(B) The licensee and other caregivers may not accept gifts from the residents through undue influence or accept gifts of substantial value. Caregivers and family members of the caregivers may not accept gifts of substantial value or loans from the resident or the resident's family. The licensee or other caregivers may not influence, solicit from, or suggest to any of the residents or the residents' representatives that the residents or the residents' representatives give the caregiver or the caregiver's family money or property for any purpose.

(C) The licensee may not subject the resident or the resident's representative to unreasonable rate increases.

(k) The licensee and other caregivers may not loan money to the residents.

(9) RESIDENT'S RIGHTS.

(a) Resident's Bill of Rights. The licensee, the licensee's family, and employees of the home must guarantee not to violate these rights and to help the residents exercise them. The Residents' Bill of Rights provided by the Department must be explained and a copy given to each resident at the time of admission. The Residents' Bill of Rights states each resident has the right to:

(A) Be treated as an adult with respect and dignity.

(B) Be informed of all resident rights and all house policies as written in the Residency Agreement.

(C) Be encouraged and assisted to exercise constitutional and legal rights, including the right to vote.

(D) Be informed of his or her medical condition and the right to consent to or refuse treatment.

(E) Receive appropriate care, services, and prompt medical care as needed.

(F) Be free from abuse.

(G) Complete privacy when receiving treatment or personal care.

(H) Associate and communicate privately with any person of choice and send and receive personal mail unopened.

(I) Have access to, and participate in, activities of social, religious, and community groups.

(J) Have medical and personal information kept confidential.

(K) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space.

(L) Be free from chemical and physical restraints except as ordered by a physician or other qualified practitioner. Restraints are used only for medical reasons, to maximize a resident's physical functioning, and after other alternatives have been tried. Restraints are not to be used for discipline or convenience.

(M) Manage his or her own financial affairs unless legally restricted.

(N) Be free from financial exploitation. The licensee may not charge or ask for application fees or non-refundable deposits or solicit, accept, or receive money or property from a resident other than the amount agreed to for services.

(O) A written agreement regarding services to be provided and the rates to be charged. The licensee must give 30 days' written notice before any change in the rates or the ownership of the home.

(P) Not be transferred or moved out of the adult foster home without 30 calendar days' written notice and an opportunity for a hearing. A licensee may transfer a resident only for medical reasons, for the welfare of the resident or other residents, or for nonpayment.

(Q) A safe and secure environment.

(R) Be free of discrimination in regard to race, color, national origin, gender, sexual orientation, or religion.

(S) Make suggestions or complaints without fear of retaliation.

(T) Be free of discrimination in regard to the execution of an Advance Directive, Physician's Order for Life-Sustaining Treatment (POLST), or Do Not Resuscitate (DNR) orders.

(b) Providers initially licensed before January 1, 2016 have until September 1, 2018 to fully comply with this rule. Residents have the following rights and freedoms authorized by 42 CFR 441.301(c)(4) and 42 CFR 441.530(a)(1):

(A) To live under a legally enforceable Residency Agreement with protections substantially equivalent to landlord-tenant laws.

(B) The freedom and support to access food at any time.

(C) To have visitors of the resident's choosing at any time.

(D) To privacy in the resident's bedroom, and to have a lockable door in the resident's bedroom, which may be locked by the resident.

(E) To choose a roommate when sharing a bedroom.

(F) To furnish and decorate the resident's bedroom according to the Residency Agreement.

(G) The freedom and support to control the resident's schedule and activities.

(H) To privacy in the resident's bedroom.

(10) INDIVIDUALLY-BASED LIMITATIONS. This section and (11) of this rule will become effective on January 1, 2017 and must be in place no later than February 28, 2018.

(a) Individual limitations must be supported by a specific assessed need. A limitation may be implemented only with the informed consent of the resident, or the resident's legal representative. Limitations may only be considered to the rights identified in (9)(b)(B)-(H) of this rule.

(b) Limitations are not transferable between care settings.

(11) REQUIRED DOCUMENTATION FOR INDIVIDUALLY-BASED LIMITATIONS. Each limitation under consideration must be documented on the Department-approved consent form. Documentation must include:

(a) The reason the limitation is needed.

(b) The positive interventions and supports used before any individually-based limitation.

(c) Less intrusive methods that were tried before and did not work.

(d) A clear description of how the limitation supports the assessed need of the resident.

(e) A way to regularly measure if the limitation is working.

(f) When the limitation will be reviewed or removed.

(g) Informed consent from the resident or resident's legal representative, including any discrepancy between the wishes of the individual and the consent of the legal representative.

(h) An assurance that the limitation will not be harmful to the resident.

Stat. Auth.: ORS 127.520, 410.070, 441.373, 443.001, 443.004, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.767, 443.775, 443.790

Stats. Implemented: ORS 443.001-004, 443.705-825, 443.875, 443.991, 443.373

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88, Renumbered from 411-050-0445(8) thru (10); SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0447, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 50-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0660

Qualifications and Requirements for Ventilator-Assisted Care

(1) Adult foster homes that provide ventilator-assisted care for residents must meet the requirements of OAR 411-050-0660 in addition to the other requirements set forth in these rules.

(2) LICENSE REQUIRED. A person or entity may not represent themselves as operating an adult foster home that provides ventilator-assisted care or accept placement of an individual requiring ventilator-assisted care without being licensed as a ventilator-assisted care adult foster home.

(3) The licensee must comply with all HCB Settings requirements as described in OAR 411-050-0615(2), 411-050-0655(4(b)-(d), (5), (9)(b), (10) and (11).

(4) APPLICATION. An applicant or licensee must meet and maintain compliance with OAR 411-050-0610.

(a) To apply for a license to provide ventilator-assisted care, an applicant or licensee must complete the Department's ventilator-assisted care application form (SDS 448V) and submit the application with the required information and nonrefundable fee as outlined in OAR 411-050-0610 to the local licensing authority.

(b) To renew a license to provide ventilator-assisted care, a licensee must complete the Department's ventilator-assisted care application form (SDS 448V) and submit the application with the required information and nonrefundable fee as outlined in OAR 411-050-0640 to the local licensing authority.

(c) Applications are processed according to OAR 411-050-0610 and 411-050-0640.

(d) Applications must be approved by the Department prior to the issuance of a ventilator-assisted care license.

(5) QUALIFICATIONS AND TRAINING. An applicant, licensee, and all other caregivers must meet and maintain compliance with OAR 411-050-0625. In addition:

(a) The applicant, licensee, resident manager, floating resident manager, or shift caregivers, as applicable, must demonstrate one year of full-time experience in providing ventilator-assisted care.

(b) The applicant or licensee, as applicable, must have experience operating a Class 3 adult foster home in substantial compliance with these rules for at least one year.

(c) An applicant for an adult foster home providing ventilator-assisted care must be the primary caregiver and live in the home where ventilator-assisted care is to be provided for a minimum of one year from the date the initial ventilator-assisted care license is issued. The licensee may employ a resident manager to be the primary live-in caregiver after providing ventilator-assisted care for the one year period. The resident manager must be approved by the local licensing authority and the Department.

(d) The applicant, licensee, and all other caregivers must successfully complete the Department's approved training pertaining to ventilator-assisted care and other training as required. Training is required on an annual basis and must be completed by the licensee, resident manager, floating resident manager, shift caregivers, and substitute caregivers, as applicable, prior to approval of a renewed ventilator-assisted care license.

(6) CLASSIFICATION. An applicant for a ventilator-assisted care license must possess the minimum qualifications outlined in section (5) of this rule. The applicant and licensee must meet and maintain compliance with OAR 411-050-0630. The local licensing authority shall issue a Level A, Level B, or Level C ventilator-assisted care adult foster home license to qualified applicants.

(a) A licensee with a Level C ventilator-assisted care license may admit a maximum of one resident who requires ventilator-assisted care. The local licensing authority may issue a Level C license if the applicant has:

(A) Satisfied the requirements described in section (5) above; and

(B) Successfully operated a Class 3 home in substantial compliance with these rules for a period of not less than one year.

(b) A licensee with a Level B ventilator-assisted care license may admit a maximum of three residents who require ventilator-assisted care. The local licensing authority may issue a Level B license if the licensee has:

(A) Satisfied the requirements described in section (5) above; and

(B) Successfully operated and provided ventilator-assisted care in their Level C home in substantial compliance with these rules for a period of not less than one year; or

(C) The applicant or licensee, as applicable, has a current license as a health care professional in Oregon.

(c) A licensee with a Level A ventilator-assisted care license may admit a maximum of five residents who require ventilator-assisted care. The local licensing authority may issue a Level A license if the licensee has:

(A) Satisfied the requirements described in section (5) above; and

(B) Successfully operated and provided ventilator-assisted care in their Level B home in substantial compliance with these rules for a period of not less than one year.

(7) CAPACITY. An applicant and licensee must meet and maintain compliance with OAR 411-050-0632. The number of residents permitted to reside in a ventilator-assisted care adult foster home is determined by the level of the home, the ability of the staff to meet the care needs of the residents, the fire and life safety standards, and compliance with these rules. A licensee may only admit or continue to provide ventilator-assisted care for residents according to the level of the home's license. A licensee may admit other residents who do not require ventilator-assisted care within the approved license capacity listed on the home's license.

(8) OPERATIONAL STANDARDS. A licensee must meet and maintain compliance with OAR 411-050-0645. In addition:

(a) A minimum of two qualified and approved caregivers must be on site and available to meet the routine and emergency care and service needs of the residents 24 hours a day. A minimum of one of the two qualified and approved caregivers must be awake during nighttime hours.

(b) All caregivers must demonstrate competency in providing ventilator-assisted care.

(c) All caregivers must be able to evacuate the residents and any other occupants of the home within three minutes or less.

(d) The applicant and licensee must have a satisfactory system in place to ensure the caregivers are alert to the 24-hour needs of residents who may be unable to independently call for assistance.

(e) All caregivers must know how to operate the back-up generator without assistance and be able to demonstrate how to operate the back-up generator upon request by the Department or local licensing authority.

(9) FACILITY STANDARDS. An applicant and licensee must meet and maintain compliance with OAR 411-050-0650. In addition:

(a) The residents' bedrooms must be a minimum of 100 square feet, or larger if necessary, to accommodate the standard requirements of OAR 411-050-0650, the needs of the resident, and the equipment and supplies necessary for the care and services needed by individuals requiring ventilator-assisted care.

(b) Homes that provide ventilator-assisted care for residents must have a functional, emergency back-up generator. The generator must be adequate to maintain electrical service for resident needs until regular service is restored. Hard wired, back-up generators must be installed by a licensed electrician. Back-up generators must be tested monthly and the test must be documented in the facility records.

(c) The home must have a functional, interconnected carbon monoxide and smoke alarm system with back-up batteries.

(d) The home must have a functional sprinkler system and maintenance of the sprinkler system must be completed as recommended by the manufacturer. A home that does not have a functional sprinkler system but was approved to provide ventilator-assisted care prior to September 1, 2013, must install a functional whole-home sprinkler system no later than July 31, 2015.

(e) Each resident's bedroom must have a mechanism in place that enables the resident to summon a caregiver's assistance when needed. The mechanism must be within the abilities of the resident to use. The summons must be audible in all areas of the adult foster home.

(10) STANDARDS AND PRACTICES FOR CARE AND SERVICES. Licensees must meet and maintain compliance with OAR 411-050-0655. In addition:

(a) The licensee must conduct and document a thorough screening of a prospective resident on the Department's form (SDS 902).

(b) Prior to admitting a resident requiring ventilator care to the adult foster home, the licensee must obtain preauthorization from the Department.

(c) The licensee must have a primary care physician identified for each resident being considered for admission.

(d) The licensee must retain the services of a registered nurse (RN) consultant to work in the home who is licensed by the State of Oregon and trained in the care of individuals requiring ventilator-assisted care. RN services include, but are not limited to, the provision of medical consultation and supervision of resident care, skilled nursing care as needed, and delegation of nursing care to caregivers. When the licensee is an RN, a back-up RN licensed by the State of Oregon and trained in the care of individuals requiring ventilator-assisted care must be identified and available to provide nursing services in the absence of the licensee.

(e) The licensee must develop individual care plans for each resident with the RN consultant addressing the expected frequency of nursing supervision, consultation, and direct service intervention. The RN consultation must be documented on the resident's completed care plan with the RN's signature and date signed.

(f) The licensee must have physician, RN, and respiratory therapist consultation services, all licensed by the State of Oregon and trained in the care of individuals requiring ventilator-assisted care available on a 24-hour basis and for in-home visits as appropriate. The licensee must call the appropriate medical professional to attend to the emergent care needs of the residents.

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

Stats. Implemented: ORS 410.070, 443.001-004, 443.705-825, 443.875, 443.991

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88, Renumbered from 411-050-0445(8) thru (10); SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0491, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0662

Qualifications and Requirements for Limited Adult Foster Homes

(1) The licensee must comply with all requirements for HCB Settings as described in OAR 411-050-0615(2), 411-050-0655(4)(b)-(d), (5), (9)(b), (10) and (11). (See OAR chapter 411, division 004).

(2) To qualify for a limited adult foster home license the applicant or licensee must submit:

(a) A completed application for initial or renewal limited licenses.

(b) The Department's Health History and Physician's or Nurse Practitioner's Statement that indicates the applicant or licensee is physically, cognitively, and emotionally capable of providing care to a specific adult who is older or who has a physical disability and with whom the applicant has an established relationship of not less than one year. The Health History and Statement must be submitted initially and every third year or sooner if there is reasonable cause for health concerns.

(c) Documentation of the initiation of a background check or copy of an approved background check for each subject individual.

(d) Completion of the Department's Caregiver Preparatory Training Study Guide (DHS 9030) and Workbook (DHS 9030-W).

(e) A $20 non-refundable fee. If the licensee requests and is granted a variance from the capacity limitation of one resident, a $20 per bed non-refundable fee for each non-relative resident is required.

(3) The applicant or licensee must demonstrate a clear understanding of the resident's care needs.

(4) The applicant or licensee must live in the home that is to be licensed.

(5) The applicant or licensee must own, rent, or lease the home where care is being provided. The applicant or licensee must provide verification of proof of ownership or a copy of the signed and dated rental or lease agreement as applicable.

(6) A caregiver must be available at all times, 24 hours a day, seven days a week, when the resident is in the home. The caregiver must have the knowledge and ability to meet the resident's care needs. All caregivers must:

(a) Have an approved background check according to the Criminal Records and Abuse Check rules (OAR 407-007-0200 through 407-007-0370) before working in the home.

(b) Complete the Department's Caregiver Preparatory Training Study Guide (DHS 9030) and Workbook (DHS 9030-W).

(c) Be at least 18 years of age.

(7) The licensee must notify the local licensing authority if the licensee shall be absent from the home 10 days or more and the resident shall be remaining in the home during the absence. The licensee must also submit a staffing plan to the local licensing authority demonstrating coverage during the absence that meets the needs of the resident.

(8) The resident's bedroom must be in close enough proximity to the licensee or caregiver in charge to alert him or her to nighttime needs or emergencies, or the bedroom must be equipped with a functional call bell or intercom within the resident's abilities to operate.

(9) The licensee and caregiver must have a complete understanding of the resident's medications. The licensee must have a copy of current prescribing practitioner orders including, if applicable, written authorization for self-administration of medications.

(10) Medications must be stored in the original labeled container except when stored in a seven-day closed container manufactured for advanced set-up of medications.

(11) The licensee and caregiver must place used, disposable syringes and needles, and other sharp items in a puncture-resistant, red container designed for disposal of sharp items. Disposal must be according to local regulations as stated in section 411-050-0655. (See ORS 459.386-405).

(12) The licensee, the licensee's family, and employees of the home must guarantee not to violate the Resident's Rights as outlined in OAR 411-050-0655.

(13) The licensee must have a copy of any applicable legal documents, such as Advance Directive, Physician Order for Life-Sustaining Treatment (POLST), and Do Not Resuscitate (DNR) orders.

(14) The home must have a working landline and corded telephone. If the licensee has a caller identification service on the home number, the blocking feature must be disabled to allow incoming calls to be received unhindered. Voice over internet protocol (VoIP), voice over broadband (VoBB), or cellular telephone service may not be used in place of a landline.

(15) CONSTRUCTION. Interior and exterior doorways used by a resident must be wide enough to accommodate wheelchairs and walkers if used by the resident. Interior and exterior stairways must be unobstructed, equipped with handrails, and appropriate to the condition of the resident.

(16) Hardware for all exit doors and interior doors must be readily visible and have simple hardware that may not be locked against exit and must have an obvious method of operation. Hasps, sliding bolts, hooks and eyes, slide chain locks, and double key deadbolts are not permitted.

(a) The resident's bedroom must have a lockable door for the resident's privacy, as stated in OAR 411-050-0650. The locking device must release by a single-action on the inside of the room and open to a hall or common-use room.

(b) The resident shall be provided a key that only locks and unlocks his or her bedroom door.

(c) A master key to the resident's door lock must be immediately available to the licensee and all other caregivers in the home.

(d) Providers licensed before January 1, 2016 have until September 1, 2018 to fully implement (a) through (c) of this rule.

(17) If a home has a resident with impaired judgment who is known to wander away, the home must have an activated alarm system to alert a caregiver of the resident's unsupervised exit.

(18) Buildings must be of sound construction with wall and ceiling flame spread rates at least substantially comparable to wood lath and plaster or better. The maximum flame spread of finished materials may not exceed 200 and the smoke developed index may not be greater than 450. If more than 10 percent of combined wall and ceiling areas in a sleeping room or exit way is composed of readily combustible material such as acoustical tile or wood paneling, such material must be treated with an approved flame retardant coating. Exception: Buildings supplied with an approved automatic sprinkler system.

(a) MANUFACTURED HOMES. Manufactured home (formerly mobile homes) units must have been built in 1976 or later and designed for use as a home rather than a travel trailer. The unit must have a manufacturer's label permanently affixed on the unit itself that states the unit meets the requirements of the Department of Housing and Urban Development (HUD). The required label must read as follows: "As evidenced by this label No. ABC000001, the manufacturer certifies to the best of the manufacturer's knowledge and belief that this mobile home has been inspected in accordance with the requirements of the Department of Housing and Urban Development and is constructed in conformance with the Federal Mobile Home Construction and Safety Standards in effect on the date of manufacture. See date plate."

(b) If such a label is not evident and the licensee believes the unit meets the required specifications, the licensee must take the necessary steps to secure and provide verification of compliance from the manufacturer.

(c) Mobile homes built in1976 or later meet the flame spread rate requirements and do not have to have paneling treated with a flame retardant coating.

(19) The applicant or licensee must meet minimal fire safety standards including:

(a) A functional smoke alarm with back-up battery must be installed in all sleeping areas and hallways or access ways that adjoin sleeping areas.

(b) A functional carbon monoxide alarm with back-up battery must be installed within 15 feet of each bedroom and at a height as recommended by the manufacturer.

(c) At least one fire extinguisher with a minimum classification of 2-A:10-B:C must be mounted in a visible and readily accessible location on each floor, including basements, and be checked at least once a year by a qualified person who is well versed in fire extinguisher maintenance. All recharging and hydrostatic testing must be completed by a qualified agency properly trained and equipped for this purpose.

(d) The licensee must have a safe evacuation plan and may be required to demonstrate the evacuation plan. The licensee may be required to install an Americans with Disabilities Act (ADA) compliant ramp for the safety of all occupants.

(e) The licensee and all occupants must be able to evacuate within three minutes to an initial point of safety exterior to and away from the structure, with access to a public sidewalk or street. The licensee and all occupants must be able to demonstrate the ability to further evacuate all occupants from the initial point of safety to the final point of safety within two minutes or less.

(f) Smoking is prohibited in any bedroom, including that of the resident, the licensee, occupants, or caregivers and in any room where oxygen is used or stored.

(g) The home must be built of standard construction and must meet all applicable state and local building, mechanical, and housing codes for fire and life safety.

(h) A resident must have a bedroom that:

(A) Was constructed as a bedroom when the home was built or remodeled under permit.

(B) Is finished with walls or partitions of standard construction that go from floor to ceiling.

(C) Has a door large enough to accommodate the occupant of the room and any equipment that may be necessary such as a hospital bed or wheelchair.

(D) Has adequate ventilation, heat, and lighting with at least one operable window or exterior door that leads directly outside as a secondary egress for resident use.

(E) Has at least 70 square feet of usable floor space.

(i) All exit ways, including windows, must remain unobstructed at all times.

(j) Flammable materials must not be stored within 36 inches of open flame or heat sources.

(k) Only sealed electric transfer heaters or electric space heaters with tip-over shut-off capability may be used when approved by the State Fire Marshal or State Fire Marshal's designee. Heaters must be plugged directly into an outlet and may not be used with extension cords.

(l) The licensee must install or make available, any supportive device necessary to meet the resident's needs and ensure resident safety including, but not limited to, grab bars, ramps, and door alarms.

(20) A license is not transferable and does not apply to any location or person other than the location and the person indicated on the license obtained from the local licensing authority.

(21) The licensee must notify the local licensing authority at least 30 days before any change in residential or mailing address.

(22) The Department, the local licensing authority, and the Centers for Medicare and Medicaid Services (CMS) have authority to conduct inspections with or without advance notice to the licensee or the resident of a home. The licensee must allow and authorize other caregivers and occupants to permit entrance and access to the home and the resident for the purpose of assessing, monitoring, inspection, investigation, and other duties within the scope of the Department, the local licensing authority, or CMS.

(23) The applicant or licensee must obtain any training and maintain resident record documentation deemed necessary by the Department to provide adequate care for the resident.

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
Stats. Implemented: ORS 443.001-004, 443.705-825, 443.875, 443.991
Hist.: SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0665
Abuse Reporting, Complaints, and Notification of Findings

(1) ABUSE REPORTING. Abuse is prohibited. The facility employees and licensee may not permit, aid, or engage in abuse of residents. Abuse and suspected abuse must be reported in accordance with OAR 411-020-0020.

(a) STAFF REPORTING. All facility employees must immediately report abuse and suspected abuse to the investigative authority.

(b) LICENSEE REPORTING. The licensee must immediately notify the investigative authority of any incident of abuse or suspected abuse, including events overheard or witnessed by observation.

(c) LAW ENFORCEMENT AGENCY. The local law enforcement agency must be called first when the suspected abuse is believed to be a crime (e.g., rape, murder, assault, burglary, kidnapping, theft of controlled substances).

(2) IMMUNITY AND PROHIBITION OF RETALIATION.

(a) The licensee may not retaliate against any resident after the resident or someone acting on the resident's behalf has filed a complaint in any manner, including, but not limited to:

(A) Increasing or threatening to increase charges;

(B) Decreasing or threatening to decrease services;

(C) Withholding rights or privileges;

(D) Taking or threatening to take any action to coerce or compel the resident to leave the facility; or

(E) Threatening to harass or abuse a resident in any manner.

(b) The licensee must ensure any complainant, witness, or employee of a facility is not subjected to retaliation by any caregiver, (including the caregiver's family and friends who may live in or frequent the adult foster home) for making a report, being interviewed about a complaint, or being a witness, including, but not limited to, restriction of access to the home or a resident or, if an employee, dismissal or harassment.

(c) Anyone who, in good faith, reports abuse or suspected abuse has immunity, as approved by law, from any civil liability that might otherwise be incurred or imposed with respect to the making or content of an abuse complaint.

(3) Immunity under this rule does not protect self-reporting licensees from liability for the underlying conduct that is alleged in the complaint.

(4) The local licensing authority must furnish each adult foster home with a Complaint Notice that states the telephone number of the Department, the investigative authority, and the Long-Term Care Ombudsman, and the procedure for making complaints.

(5) Any person who believes these rules have been violated may file a complaint with the Department, the local licensing authority, or the investigative authority.

(6) The Department or the investigative authority shall investigate complaints in accordance with the adult protective services rules in OAR chapter 411, division 20 or OAR chapter 407, division 45, as applicable.

(7) Immediate protection shall be provided for the residents by the Department, the local licensing authority, or the investigative authority, as necessary, regardless of whether the investigative report is completed. The licensee must immediately cease any practice that places a resident at risk of serious harm.

(8) PRELIMINARY FINDINGS. The Department, through the investigative authority, shall provide, by written communication or electronic mail, a copy of the preliminary abuse investigation report to the licensee and complainant within seven business days of the completion of the investigation:

(a) The report shall be accompanied by a notice informing the licensee and complainant of the right to give additional information about the content of the report to the investigative authority within 10 calendar days of receipt of the report.

(b) The investigative authority must review the responses and reopen the investigation or amend the report if the additional evidence warrants a change.

(9) A copy of the entire report shall be sent to the Department upon completion of the investigation report.

(10) NOTIFICATION OF FINDINGS. Upon a determination of substantiated abuse or a rule violation, the Department must provide written notification of its findings to the licensee.

(a) CONTENT. The written notice shall:

(A) Explain the nature of each allegation.

(B) Include the date and time of each occurrence.

(C) For each allegation, include a determination of whether the allegation is substantiated, unsubstantiated, or inconclusive.

(D) For each substantiated allegation, state whether the violation was abuse or another rule violation.

(E) Include a copy of the complaint investigation report.

(F) State that the complainant, any person reported to have committed wrongdoing, and the facility have 15 calendar days to provide additional or different information.

(G) For each allegation, explain the applicable appeal rights available.

(b) APPORTIONMENT. If the Department determines there is substantiated abuse, the Department may determine the licensee, an individual, or both the licensee and an individual were responsible for abuse. In determining responsibility, the Department shall consider intent, knowledge, and ability to control, and adherence to professional standards, as applicable.

(A) LICENSEE RESPONSIBLE. Examples of when the Department shall determine the licensee is responsible for the abuse include, but are not limited to, the following:

(i) Failure to provide sufficient, qualified staffing in accordance with these rules without reasonable effort to correct.

(ii) Failure to check for or act upon relevant information available from a licensing board.

(iii) Failure to act upon information from any source regarding a possible history of abuse by any staff or prospective staff.

(iv) Failure to adequately train, orient, or provide sufficient oversight to staff.

(v) Failure to provide adequate oversight to residents.

(vi) Failure to allow sufficient time to accomplish assigned tasks.

(vii) Failure to provide adequate services.

(viii) Failure to provide adequate equipment or supplies.

(ix) Failure to follow orders for treatment or medication.

(B) INDIVIDUAL RESPONSIBLE. Examples of when the Department determines an individual is responsible include, but is not limited to:

(i) Intentional acts against a resident, including assault, rape, kidnapping, murder, or sexual, verbal, or mental abuse.

(ii) Acts contradictory to clear instructions from the facility, such as those identified in section (10)(b)(A) of this rule, unless the act is determined by the Department to be the responsibility of the facility.

(iii) Callous disregard for resident rights or safety.

(iv) Intentional acts against a resident's property (e.g., theft or misuse of funds).

(C) An individual shall not be considered responsible for the abuse if the individual demonstrates the abuse was caused by factors beyond the individual's control. "Factors beyond the individual's control" are not intended to include such factors as misuse of alcohol or drugs or lapses in sanity.

(D) NURSING ASSISTANTS. In cases of substantiated abuse by a nursing assistant, the written notice shall explain:

(i) The Department's intent to enter the finding of abuse into the Nursing Assistant Registry following the procedure set out in OAR 411-089-0140; and

(ii) The nursing assistant's right to provide additional information and request a contested case hearing as provided in OAR 411-089-0140.

(c) DISTRIBUTION.

(A) The written notice shall be mailed to:

(i) The licensee;

(ii) Any person reported to have committed wrongdoing;

(iii) The complainant, if known;

(iv) The Long-term Care Ombudsman; and

(v) The local licensing authority.

(B) A copy of the written notice must be placed in the Department's facility complaint file.

(11) Upon receipt of a notice that substantiates abuse for victims covered by ORS 430.735, the facility must provide written notice of the findings to the individual found to have committed abuse, residents of the facility, and the residents' case manager and representatives.

(12) Licensees who acquire substantiated complaints pertaining to the health, safety, or welfare of residents may be assessed civil penalties, have conditions placed on their licenses, or have their licenses suspended, revoked, or not renewed.

(13) COMPLAINT REPORTS. Copies of all completed complaint reports must be maintained and available to the public at the local licensing

authority. Individuals may purchase a photocopy upon requesting an appointment to do so.

(14) The Department and the local licensing authority shall not disclose information that may be used to identify a resident in accordance with OAR 411-020-0030 (Confidentiality) and federal HIPAA Privacy Rules. Completed reports placed in the public file must be in compliance with OAR 411-050-0670 and must:

(a) Protect the privacy of the complainant and the resident. The identity of the person reporting suspected abuse must be confidential and may be disclosed only with the consent of that person, by judicial process (including administrative hearing), or as required to perform the investigation by the Department or a law enforcement agency.

(b) Treat the names of the witnesses as confidential information.

(c) Clearly designate the final disposition of the complaint.

(A) PENDING COMPLAINT REPORTS. Any information regarding the investigation of the complaint may not be filed in the public file until the investigation has been completed.

(B) COMPLAINT REPORTS AND RESPONSES. The investigation reports, including copies of the responses with confidential information deleted, must be available to the public at the local licensing authority office along with other public information regarding the adult foster home.

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

Stats. Implemented: ORS 124.050, 124.060, 124.075, 443.001-004, 443.705-825, 443.875, 443.991

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SDSD 11-2001, f. 12-21-01, cert. ef. 1-1-02; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10; Renumbered from 411-050-0455, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 50-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; APD 15-2015, f. 6-24-15, cert. ef. 6-28-15; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0670
Inspections

(1) The local licensing authority must conduct an inspection of an adult foster home and all structures on the adult foster home property:

(a) Before issuance of a license;

(b) Before the annual renewal of a license. The local licensing authority must conduct this inspection unannounced;

(c) Upon receipt of an oral or written complaint of violations that threaten the health, safety, or welfare of residents; or

(d) Anytime the Department has probable cause to believe a home has violated a regulation or provision of these rules or is operating without a license.

(2) The Department may conduct inspections:

(a) Any time such inspections are authorized by these rules and any other time the Department considers it necessary to determine if a home is in compliance with these rules or with conditions placed upon the license.

(b) To determine if cited violations have been corrected.

(c) For the purpose of routine monitoring of the residents' care.

(3) State or local fire inspectors must be permitted access to enter and inspect adult foster homes regarding fire safety upon the Department's request.

(4) The Department, the local licensing authority, the investigative authority, and the Centers for Medicare and Medicaid Services (CMS) have authority and must have full access to examine and copy facility and resident records, including, but not limited to, Residency Agreements, and resident account records, as applicable.

(5) PRIVATE INTERVIEW. Department, local licensing authority, investigative authority, and CMS staff have authority to interview the licensee, resident manager, other caregivers, and the residents. Interviews must be confidential and conducted privately.

(6) Licensees must authorize all staff to permit the Department, local licensing authority, the investigative authority, and CMS staff, for the purpose of inspection, investigation, and other duties within the scope of the inspector's or investigator's authority:

(a) Entrance to the adult foster home and any other structure on the premises; and

(b) Access to resident and facility records.

(7) The Department, local licensing authority, the investigative authority, and CMS has authority to conduct inspections with or without advance notice to the licensee, staff, or the residents of the home. The Department, local licensing authority, and CMS shall not give advance notice of any inspection if it is believed that notice might obstruct or seriously diminish the effectiveness of the inspection or enforcement of these rules.

(8) If Department, local licensing authority, the investigative authority, or CMS staff are not permitted access for inspection, a search warrant may be obtained.

(9) The inspector must respect the private possessions of the residents, licensee, and staff while conducting an inspection.

(10) PUBLIC FILE. The local licensing authority must maintain current information on all licensed adult foster homes and must make all non-confidential information available to prospective residents and other interested members of the public at local licensing authority offices throughout the state as authorized by law. The information includes:

(a) The location of the adult foster home and the name and mailing address of the licensee if different.

(b) A brief description of the physical characteristics of the home.

(c) A copy of the current license that indicates the current classification, level, and capacity of the home, as applicable.

(d) The date the licensee was first licensed to operate that home.

(e) The date of the last licensing inspection including any fire inspection, the name and telephone number of the office that performed the inspection, and a summary of the inspection findings.

(f) Copies of all non-confidential portions of complaint investigations involving the home, together with the findings, actions taken by the Department, and responses from the licensee and complainant, as appropriate. All complaint terminology must be clearly defined and the final disposition clearly designated.

(g) Any license conditions, suspensions, denials, revocations, non-renewals, civil penalties, variances, or other actions taken by the Department involving the home.

(h) Whether care is provided primarily by the licensed provider, a resident manager, or shift caregivers.

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

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

Hist.: SSD 14-1985, f. 12-31-85, ef. 1-1-86; SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; Renumbered from 411-050-0450, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

411-050-0685
Civil Penalties

(1) Except as otherwise provided in this rule, civil penalties, not to exceed $100 per violation to a maximum of $250, may be assessed for a general violation of these rules.

(2) Mandatory penalties up to $500, unless otherwise required by law, shall be assessed for falsifying resident or facility records or causing another to do so.

(3) A mandatory penalty of $250 shall be imposed for failure to have either the licensee or other qualified caregiver on duty 24 hours per day in the adult foster home.

(4) A mandatory penalty of $250 shall be imposed for dismantling or removing the battery from any required smoke alarm or failing to install any required smoke alarm.

(5) The Department shall impose a civil penalty of not less than $250 and no more than $500 on a licensee who admits a resident knowing that the resident's care needs exceed the license classification of the licensee and the admission places the resident or other residents at risk of harm.

(6) Civil penalties up to a maximum of $1,000 per occurrence may be assessed for substantiated abuse.

(7) If the Department, or the Department's designee, conducts an investigation and abuse is substantiated and if the abuse resulted in the death, serious injury, rape, or sexual abuse of a resident, the Department shall impose a civil penalty of not less than $2,500 for each violation.

(a) To impose this civil penalty, the Department must establish:

(A) The abuse arose from deliberate or other than accidental action or inaction.

(B) The conduct resulting in the abuse was likely to cause death, serious injury, rape, or sexual abuse of a resident.

(C) The person with the finding of abuse had a duty of care toward the resident.

(b) For the purposes of this civil penalty, the following definitions apply:

(A) "Serious injury" means a physical injury that creates a substantial risk of death or that causes serious disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.

(B) "Rape" means rape in the first, second, or third degree as described in ORS 163.355, 163.365, and 163.375.

(C) "Sexual abuse" means any form of nonconsensual sexual contact including, but not limited to, unwanted or inappropriate touching, sodomy, sexual coercion, sexually explicit photographing, or sexual harassment. The sexual contact must be in the form of any touching of the sexual or other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party.

(D) "Other than accidental" means failure on the part of the licensee, or licensee's employees, agents, or volunteers for whose conduct licensee is responsible, to comply with applicable Oregon Administrative Rules.

(8) In addition to any other liability or penalty provided by law, the Department may impose a penalty for any of the following:

(a) Operating the home without a license.

(b) The number of residents exceeds the licensed capacity.

(c) The licensee fails to achieve satisfactory compliance with the requirements of these rules within the time specified, or fails to maintain such compliance.

(d) The home is unable to provide adequate level of care to the residents.

(e) There is retaliation or discrimination against a resident, family, employee, or any other person for making a complaint against the home.

(f) The licensee fails to cooperate with the Department or fails to cooperate with the prescribing practitioner or licensed health care professional in carrying out a resident's care plan.

(g) The licensee fails to obtain an approved background check from the Department before employing a caregiver in the home.

(9) A civil penalty may be imposed for violations other than those involving the health, safety, or welfare of a resident if the licensee fails to correct the violation as required when a reasonable time frame for correction was given.

(10) Violations requiring a mandatory civil penalty, which occurred while the licensee was operating the AFH, will be imposed by the Department, even if the licensee subsequently closes the home or voluntarily surrenders the license.

(11) Any civil penalty imposed under this rule becomes due and payable 10 calendars days after the order imposing the civil penalty becomes final by operation of law or on appeal. The notice must be delivered in person or sent by registered or certified mail and must include:

(a) A reference to the particular sections of the statute, rule, standard, or order involved.

(b) A short and plain statement of the matters asserted or charged.

(c) A statement of the amount of the penalty or penalties imposed.

(d) A statement of the right to request a hearing.

(12) The person to whom the notice is addressed shall have 10 calendar days after receipt of the notice to make written application for a hearing. If a written request for a hearing is not timely received, the Department shall issue a final order by default.

(13) All hearings shall be conducted according to the applicable provisions of ORS 183.

(14) When imposing a civil penalty, the Department shall consider the following factors:

(a) The past history of the person incurring the penalty in taking all feasible steps or procedures to correct the violation;

(b) Any prior violations of statutes, rules, or orders pertaining to the facility;

(c) The economic and financial conditions of the person incurring the penalty;

(d) The immediacy and extent to which the violation threatens or threatened the health, safety, or welfare of one or more residents; and

(e) The degree of harm to residents.

(15) If the person notified fails to request a hearing within the time specified, or if after a hearing the person is found to be in violation of a license, rule, or order, an order may be entered assessing a civil penalty.

(16) Unless the penalty is paid within 10 calendar days after the order becomes final, the order constitutes a judgment and may be recorded by the county clerk, which becomes a lien upon the title to any interest in real property owned by that person. The Department may also initiate a notice of revocation for failure to comply with a final order.

(17) Civil penalties are subject to judicial review under ORS 183.480, except that the court may, at its discretion, reduce the amount of the penalty.

(18) All penalties recovered under ORS 443.790 to 443.815 are paid to the Quality Care Fund.

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

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

Hist.: SSD 11-1988, f. 10-18-88, cert. ef. 11-1-88; SSD 3-1992, f. 5-26-92, cert. ef. 6-1-92; SSD 3-1996, f. 3-29-96, cert. ef. 4-1-96; SDSD 4-2001, f. & cert. ef. 3-1-01; SPD 31-2006, f. 12-27-06, cert. ef. 1-1-07; SPD 22-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 9-2010, f. 6-30-10, cert. ef. 7-1-10 Renumbered from 411-050-0487, SPD 33-2013, f. 8-30-13, cert. ef. 9-1-13; APD 6-2014, f. 3-31-14, cert. ef. 4-1-14; APD 27-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 9-2016, f. 6-27-16, cert. ef. 6-28-16

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Rule Caption: Residential Care and Assisted Living Facilities
Adm. Order No.: APD 10-2016
Filed with Sec. of State: 6-27-2016
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Notice Publication Date: 5-1-2016
Rules Adopted: 411-054-0038
Rules Amended: 411-054-0000, 411-054-0005, 411-054-0012, 411-054-0025, 411-054-0027, 411-054-0034, 411-054-0036, 411-054-0065, 411-054-0080, 411-054-0120
Rules Repealed: 411-054-0000(T), 411-054-0005(T), 411-054-0012(T), 411-054-0025(T), 411-054-0027(T), 411-054-0036(T), 411-054-0038(T)
Subject: The Department of Human Services (Department) is amending OAR chapter 411, division 054 to permanently update the rules that became effective on January 1, 2016. The Department is amending the rules and adopting a new rule to add in requirements surrounding individually-based limitations for residential care and assisted living facilities to align the rules with the newly adopted rules in 411-004. The rules in 411-004 provide a foundation of standards to support the network of Medicaid-funded and private pay residential Home and Community-Based Services (HCBS), Home and Community-Based (HCB) settings, and person-centered service planning for individuals receiving HCBS in Oregon.

The amended rules ensure individuals in residential care and assisted living and facilities receive HCBS in settings that are integrated in and support the same degree of access to the greater community as people not receiving HCBS, including opportunities for individuals enrolled in or utilizing HCBS to:

- Engage in community life;
- Control personal resources; and
- Receive services in the community.

The Department is also updating language in 411-054-0012 (Market Study language) to comply with H.B. 2413 (2015) and 411-054-0025 (Criminal Background language) to comply with H.B. 4151 (2015).

The Department is updating the rules to match current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-054-0000
Purpose

(1) The purpose of these rules is to establish standards for assisted living and residential care facilities that promote the availability of a wide range of individualized services for elderly and persons with disabilities, in a homelike environment. The standards are designed to enhance the dignity, independence, individuality, and decision making ability of the resident in a safe and secure environment while addressing the needs of the resident in a manner that supports and enables the individual to maximize abilities to function at the highest level possible.

(2) Residential care and assisted living facilities are also required to adhere to Home and Community-Based Services, OAR 411-004. For purposes of these rules, all residential care and assisted living facilities are considered home and community-based care settings and therefore shall be referred to as "facility".

Stat. Auth.: ORS 410.070 & 443.450

Stats. Implemented: ORS 443.400 - 443.455, 443.991

Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; APD 26-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0005
Definitions

For the purpose of these rules, the following definitions apply:

(1) "Abuse" means abuse as defined in OAR 411-020-0002 (Adult Protective Services).

(2) "Activities of Daily Living (ADL)" mean those personal functional activities required by an individual for continued well-being, health, and safety. Activities consist of eating, dressing, grooming, bathing, personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), cognition, and behavior.

(3) "Acute Sexual Assault" means any non-consensual or unwanted sexual contact that warrants medical treatment or forensic collection.

(4) "Administrator" means the individual who is designated by the licensee that is responsible for the daily operation and maintenance of the facility as described in OAR 411-054-0065.

(5) "Advance Directive" means a document that contains a health care instruction or a power of attorney for health care.

(6) "Aging and People with Disabilities" means the program area of Aging and People with Disabilities, within the Department of Human Services.

(7) "APD" means "Aging and People with Disabilities".

(8) "Applicant" means the individual, individuals, or entity, required to complete a facility application for license.

(a) Except as set forth in OAR 411-054-0013(1)(b), applicant includes a sole proprietor, each partner in a partnership, and each member with a 10 percent or more ownership interest in a limited liability company, corporation, or entity that:

(A) Owns the residential care or assisted living facility business; or

(B) Operates the residential care or assisted living facility on behalf of the facility business owner.

(b) Except as set forth in OAR 411-054-0013(1)(b), for those who serve the Medicaid population, applicant includes a sole proprietor, each partner in a partnership, and each member with a five percent or more ownership interest in a limited liability company, corporation, or entity that:

(A) Owns the residential care or assisted living facility business; or

(B) Operates the residential care or assisted living facility on behalf of the facility business owner.

(9) "Area Agency on Aging (AAA)" as defined in ORS 410.040 means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors or individuals with disabilities in a planning and service area. For the purpose of these rules, the term Area Agency on Aging is inclusive of both Type A and B Area Agencies on Aging that contract with the Department to perform specific activities in relation to residential care and assisted living facilities including:

(a) Conducting inspections and investigations regarding protective service, abuse, and neglect.

(b) Monitoring.

(c) Making recommendations to the Department regarding facility license approval, denial, revocation, suspension, non-renewal, and civil penalties.

(10) "Assisted Living Facility (ALF)" means a building, complex, or distinct part thereof, consisting of fully, self-contained, individual living units where six or more seniors and adult individuals with disabilities may reside in homelike surroundings. The assisted living facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs of the residents as described in these rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, and independence.

(11) "Building Codes" are comprised of the set of specialty codes, including the Oregon Structural Specialty Code (OSSC), Oregon Mechanical Specialty Code (OMSC), Oregon Electrical Specialty Code (OESC), Oregon Plumbing Specialty Code (OPSC), and their reference codes and standards.

(12) "Caregiver" means a facility employee who is trained in accordance with OAR 411-054-0070 to provide personal care services to residents. The employee may be either a direct care staff or universal worker.

(13) "Change in Use" means altering the purpose of an existing room, within the facility, that requires structural changes.

(14) "Change of Condition - Short-Term" means a change in the resident's health or functioning, that is expected to resolve or be reversed with minimal intervention, or is an established, predictable, cyclical pattern associated with a previously diagnosed condition.

(15) "Change of Condition - Significant" means a major deviation from the most recent evaluation, that may affect multiple areas of functioning or health, that is not expected to be short-term, and imposes significant risk to the resident. Examples of significant change of condition include, but are not limited to:

(a) Broken bones;

(b) Stroke, heart attack, or other acute illness or condition onset;

(c) Unmanaged high blood sugar levels;

(d) Uncontrolled pain;

(e) Fast decline in activities of daily living;

(f) Significant unplanned weight loss;

(g) Pattern of refusing to eat;

(h) Level of consciousness change; and

(i) Pressure ulcers (stage 2 or greater).

(16) "Choice" means a resident has viable options that enable the resident to exercise greater control over his or her life. Choice is supported by the provision of sufficient private and common space within the facility that allows residents to select where and how to spend time and receive personal assistance.

(17) "CMS" means the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

(18) "Condition" means a provision attached to a new or existing license that limits or restricts the scope of the license or imposes additional requirements on the licensee.

(19) "Department" means the Department of Human Services (DHS).

(20) "Designated Representative" means:

(a) Any adult, such as a parent, family member, guardian, advocate, or other person, who is:

(A) Chosen by the individual or, as applicable, the legal representative;

(B) Not a paid provider for the individual; and

(C) Authorized by the individual, or as applicable the legal representative, to serve as the representative of the individual, or as applicable the legal representative, in connection with the provision of funded supports.

(D) The power to act as a designated representative is valid until the individual modifies the authorization or notifies the agency that the designated representative is no longer authorized to act on his or her behalf.

(b) An individual or the legal representative of the individual is not required to appoint a designated representative.

(21) "Dignity" means providing support in such a way as to validate the self-worth of the individual. Dignity is supported by creating an environment that allows personal assistance to be provided in privacy and by delivering services in a manner that shows courtesy and respect.

(22) "Direct Care Staff" means a facility employee whose primary responsibility is to provide personal care services to residents. These personal care services may include:

(a) Medication administration.

(b) Resident-focused activities.

(c) Assistance with activities of daily living.

(d) Supervision and support of residents.

(e) Serving meals, but not meal preparation.

(23) "Directly Supervised" means a qualified staff member maintains visual contact with the supervised staff.

(24) "Director" means the Director of the Department or that individual's designee.

(25) "Disaster" means a sudden emergency occurrence beyond the control of the licensee, whether natural, technological, or man-made, that renders the licensee unable to operate the facility or makes the facility uninhabitable.

(26) "Disclosure" means the written information the facility is required to provide to consumers to enhance the understanding of facility costs, services, and operations.

(27) "Entity" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation of a state.

(28) "Exception" means a written variance granted by the Department from a regulation or provision of these rules.

(29) "Facility" means the residential care or assisted living facility licensee and the operations, policies, procedures, and employees of the residential care or assisted living facility. For purposes of HCBS, "facility" can also mean "provider".

(30) "FPS" means the Facilities, Planning, and Safety Program within the Public Health Division of the Oregon Health Authority (OHA).

(31) "HCB" means "Home and Community-Based".

(32) "HCBS" means "Home and Community-Based Services." HCBS are services provided in the home or community of an individual. DHS, Office of Licensing and Regulatory Oversight and OHA provide

oversight and license, certify, and endorse programs, settings, or settings designated as HCB.

(33) "Homelike Environment" means a living environment that creates an atmosphere supportive of the resident's preferred lifestyle. Homelike environment is also supported by the use of residential building materials and furnishings.

(34) "Incident of Ownership" means an ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interests.

(35) "Independence" means supporting resident capabilities and facilitating the use of those abilities. Creating barrier free structures and careful use of assistive devices supports independence.

(36) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in another entity. Indirect ownership interest includes an ownership interest in an entity that has an indirect ownership interest in another entity.

(37) "Individual" means a person enrolled in or utilizing HCBS.

(38) "Individually-Based Limitation" means any limitation to the qualities outlined in OAR 411-004-0020(2)(d) to (2)(j), due to health and safety risks. An individually-based limitation is based on specific assessed need and only implemented with the informed consent of the individual, or as applicable the legal representative, as described in OAR 411-004-0040.

(39) "Informed Consent" means options, risks, and benefits have been explained to an individual, and, as applicable, the legal representative of the individual, in a manner that the individual, and, as applicable, the legal representative, comprehends.

(40) "Individuality" means recognizing variability in residents' needs and preferences and having flexibility to organize services in response to different needs and preferences.

(41) "Licensed Nurse" means an Oregon licensed practical or registered nurse.

(42) "Licensee" means the entity that owns the residential care or assisted living facility business, and to whom an assisted living or residential care facility license has been issued.

(43) "Legal Representative" means a person who has the legal authority to act for an individual.

(a) The legal representative only has authority to act within the scope and limits of his or her authority as designated by the court or other agreement. Legal representatives acting outside of his or her authority or scope must meet the definition of designated representative.

(b) For an individual 18 years of age and older, a guardian appointed by a court order or an agent legally designated as the health care representative, where the court order or the written designation provide authority for the appointed or designated person to make the decisions indicated where the term "legal representative" is used in this rule.

(44) "Major Alteration":

(a) Means:

(A) Any structural change to the foundation, floor, roof, exterior, or load bearing wall of a building;

(B) The addition of floor area to an existing building; or

(C) The modification of an existing building that results in a change in use where such modification affects resident services or safety.

(b) Does not include, cosmetic upgrades to the interior or exterior of an existing building (for example: changes to wall finishes, floor rings, or casework).

(45) "Management" or "Operator" means possessing the right to exercise operational or management control over, or directly or indirectly conduct, the day-to-day operation of a facility.

(46) "Modified Special Diet" means a diet ordered by a physician or other licensed health care professional that may be required to treat a medical condition (for example: heart disease or diabetes).

(a) Modified special diets include, but are not limited to:

(A) Small frequent meals;

(B) No added salt;

(C) Reduced or no added sugar; and

(D) Simple textural modifications.

(b) Medically complex diets are not included.

(47) "New Construction" means:

(a) A new building.

(b) An existing building or part of a building that is not currently licensed.

(c) A major alteration to an existing building.

(d) Additions, conversions, renovations, or remodeling of existing buildings.

(48) "Nursing Care" means the practice of nursing as governed by ORS chapter 678 and OAR chapter 851.

(49) "OHA" means the Oregon Health Authority.

(50) "Owner" means an individual with an ownership interest.

(51) "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of an entity.

(52) "Person-Centered Service Plan" means the details of the supports, desired outcomes, activities, and resources required for an individual to achieve and maintain personal goals, health, and safety, as described in OAR 411-004-0030.

(a) FOR INDIVIDUALS RECEIVING MEDICAID. The person-centered service plan coordinator completes the person-centered service plan.

(b) FOR NON-MEDICAID INDIVIDUALS. The person-centered service plan may be completed by the resident, and as applicable, the representative of the individual, and others as chosen by the individual. The licensee may assist non-Medicaid individuals in developing person-centered service plans when no alternative resources are available. The elements of the individual's person-centered service plan may be incorporated into the resident's care plan.

(53) "Person-Centered Service Plan Coordinator" means a:

(a) Resident's AAA or APD case manager assigned to provide case management services or person-centered service planning for and with individuals; or

(b) Person of the individual's choice for individuals who pay privately.

(54) "Personal Incidental Funds (PIF)" means the monthly amount allowed each Medicaid resident for personal incidental needs. For purposes of this definition, personal incidental funds include monthly payments, as allowed, and previously accumulated resident savings.

(55) "Privacy" means a specific area or time over which the resident maintains a large degree of control. Privacy is supported with services that are delivered with respect for the resident's civil rights.

(56) "Provider" means any person or entity providing HCBS.

(57) "P.R.N." means those medications and treatments that have been ordered by a qualified practitioner to be administered as needed.

(58) "Psychoactive Medications" mean medications used to alter mood, level of anxiety, behavior, or cognitive processes. Psychoactive medications include antidepressants, anti-psychotics, sedatives, hypnotics, and anti-anxiety medications.

(59) "Remodel" means a renovation or conversion of a building that requires a building permit and meets the criteria for review by the Facilities Planning and Safety Program as described in OAR 333-675-0000.

(60) "Renovate" means to restore to good condition or to repair.

(61) "Residency Agreement" means the written, legally enforceable agreement between a facility and an individual, or legal representative receiving services in a residential setting.

(62) "Resident" means any individual who is receiving room, board, care, and services on a 24-hour basis in a residential care or assisted living facility for compensation.

(63) "Residential Care Facility (RCF)" means a building, complex, or distinct part thereof, consisting of shared or individual living units in a homelike surrounding, where six or more seniors and adult individuals with disabilities may reside. The residential care facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs of the residents as described in these rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, individuality, and independence.

(64) "Restraint" means any physical device the resident cannot manipulate that is used to restrict movement or normal access to the resident's body.

(65) "Retaliation" means to threaten, intimidate, or take an action that is detrimental to an individual (for example, harassment, abuse, or coercion).

(66) " Risk Agreement" means a process where a resident's high-risk behavior or choices are reviewed with the resident. Alternatives to and consequences of the behavior or choices are explained to the resident and the resident's decision to modify behavior or accept the consequences is documented.

(67) "Service Plan" means a written, individualized plan for services, developed by a service planning team and the resident or the resident's legal representative, that reflects the resident's capabilities, choices, and if applicable, measurable goals, and managed risk issues. The service plan defines the division of responsibility in the implementation of the services.

(68) "Service Planning Team" means two or more individuals, as set forth in OAR 411-054-0036, that assist the resident in determining what services and care are needed, preferred, and may be provided to the resident.

(69) "Services" mean supervision or assistance provided in support of a resident's needs, preferences, and comfort, including health care and activities of daily living, that help develop, increase, maintain, or maximize the resident's level of independent, psychosocial, and physical functioning.

(70) "Subject Individual" means any individual 16 years of age or older on whom the Department may conduct a background check as defined in OAR 407-007-0210 and from whom the Department may require fingerprints for the purpose of conducting a national background check.

(a) For the purpose of these rules, subject individual includes:

(A) All applicants, licensees, and operators of a residential care or assisted living facility;

(B) All individuals employed or receiving training in an assisted living or residential care facility; and

(C) Volunteers, if allowed unsupervised access to residents.

(b) For the purpose of these rules, subject individual does not apply to:

(A) Residents and visitors of residents; or

(B) Individuals that provide services to residents who are employed by a private business not regulated by the Department.

(71) "Supportive Device" means a device that may have restraining qualities that supports and improves a resident's physical functioning.

(72) "These Rules" mean the rules in OAR chapter 411, division 054.

(73) "Underserved" means services are significantly unavailable within the service area in a comparable setting for:

(a) The general public.

(b) A specific population, for example, residents with dementia or traumatic brain injury.

(74) "Unit" means the personal and sleeping space of an individual receiving services in a RCF or ALF setting, as agreed to in the Residency Agreement.

(75) "Universal Worker" means a facility employee whose assignments include other tasks (for example, housekeeping, laundry, or food service) in addition to providing direct resident services. Universal worker does not include administrators, clerical or administrative staff, building maintenance staff, or licensed nurses who provide services as specified in OAR 411-054-0034.

Stat. Auth.: ORS 410.070 & 443.450

Stats. Implemented: ORS 443.400 - 443.455 & 443.991

Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; SPD 16-2008, f. 12-31-08, cert. ef. 1-1-09; SPD 13-2009, f. 9-30-09, cert. ef. 10-1-09; SPD 23-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 10-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 24-2010(Temp), f. & cert. ef. 10-5-10 thru 4-2-11; SPD 7-2011, f. 3-31-11, cert. ef. 4-1-11; SPD 23-2011(Temp), f. & cert. ef. 11-10-11 thru 5-7-12; SPD 4-2012, f. 4-30-12, cert. ef. 5-1-12; SPD 11-2012, f. 8-31-12, cert. ef. 9-1-12; APD 1-2015, f. 1-14-15, cert. ef. 1-15-15; APD 26-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0012

Requirements for New Construction or Initial Licensure

(1) An applicant requesting approval of a potential license for new construction or licensing of an existing building that is not operating as a licensed facility, must communicate with the Department before submitting a letter of intent as described in section (3) of this rule.

(2) Before beginning new construction of a building, or purchase of an existing building with intent to request a license, the applicant must provide the following information for consideration by the Department for a potential license:

(a) Demonstrate a past history, if any, of substantial compliance with all applicable state and local laws, rules, codes, ordinances, and permit requirements in Oregon, and the ability to deliver quality services to citizens of Oregon; and

(b) Provide a letter of intent as set forth in section (3) of this rule.

(3) LETTER OF INTENT. Before applying for a building permit, a prospective applicant, with intent to build or operate a facility, must submit to the Department a letter of intent that includes the following:

(a) Identification of the potential applicant.

(b) Identification of the city and street address of the intended facility.

(c) Intended facility type (for example, RCF, ALF, or memory care), the intended number of units, and maximum resident capacity.

(d) Statement of whether the applicant is able to provide care and services for an underserved population and a description of any underserved population the applicant is able to serve.

(e) Indication of whether the applicant is able to provide services through the state medical assistance program.

(f) Identification of operations within Oregon or within other states that provide a history of the applicant's ability to serve the intended population.

(g) An independent market analysis completed by a third party professional that meets the requirements of section (4) of this rule.

(4) MARKET ANALYSIS. The applicant must submit a current market analysis to the Department before applying for a building permit. A market analysis is not required for change of owner applicants of existing licensed buildings. The market analysis must include:

(a) A description of the intended population to be served, including underserved populations and those eligible to receive services through the state medical assistance program, as applicable.

(b) A current demographic overview of the area to be served.

(c) A description of the area and regional economy and the effect on the market for the project.

(d) Identification of the number of individuals in the area to be served who are potential residents.

(e) A description of available amenities (for example, transportation, hospital, shopping center, or traffic conditions).

(f) A description of the extent, types, and availability of existing and proposed facilities, as described in ORS 443.400 to 443.455, located in the area to be served.

(g) The rate of occupancy, including waiting lists, for existing and recently completed developments competing for the same market segment.

(5) The Department shall issue a written decision of a potential license within 60 days of receiving all required information from the applicant.

(a) If the applicant is dissatisfied with the decision of the Department, the applicant may request a contested case hearing in writing within 14 calendar days from the date of the decision.

(b) The contested case hearing shall be in accordance with ORS chapter 183.

(6) Before issuing a license, the Department shall consider the applicant's stated intentions and compliance with the requirements of this rule and all structural and other licensing requirements as stated in these rules.

(7) BUILDING DRAWINGS. After the letter of intent has been submitted to the Department, one set of building drawings and specifications must be submitted to FPS and must comply with OAR chapter 333, division 675.

(a) Building drawings must be submitted to FPS:

(A) Before beginning construction of any new building;

(B) Before beginning construction of any addition to an existing building;

(C) Before beginning any remodeling, modification, or conversion of an existing building that requires a building permit; or

(D) After application for an initial license of a facility not previously licensed under this rule.

(b) Drawings must comply with the building codes and the Oregon Fire Code (OFC) as required for the occupancy classification and construction type.

(c) Drawings submitted for a licensed assisted living or residential facility must be prepared by and bear the stamp of an Oregon licensed architect or engineer.

(8) 60 DAYS BEFORE LICENSURE. At least 60 days before anticipated licensure, the applicant must submit to the Department:

(a) A completed application form with the required fee.

(b) A copy of the facility's written rental agreements.

(c) Disclosure information.

(d) Facility policies and procedures to ensure the facility's administrative staff, personnel, and resident care operations are conducted in compliance with these rules.

(9) 30 DAYS BEFORE LICENSURE. 30 days before anticipated licensure the applicant must submit:

(a) To the Department, a completed and signed Administrator Reference Sheet that reflects the qualifications and training of the individual designated as facility administrator and a background check request.

(b) To FPS, a completed and signed Project Substantial Completion Notice that attests substantial completion of the building project and requests the scheduling of an onsite licensing inspection.

(10) TWO-DAYS BEFORE LICENSURE. At least two working days before the scheduled onsite licensing inspection of the facility, the applicant must submit, to the Department and FPS, a completed and signed Project

Completion/Inspection Checklist that confirms the building project is complete and fully in compliance with these rules.

(a) The scheduled, onsite licensing inspection may not be conducted until the Project Completion/Inspection Checklist has been received by both FPS and the Department.

(b) The onsite licensing inspection may be rescheduled at the Department's convenience if the scheduled, onsite licensing inspection reveals the building is not in compliance with these rules as attested to on the Project Completion/Inspection Checklist.

(11) CERTIFICATE OF OCCUPANCY. The applicant must submit to the Department and FPS, a copy of the Certificate of Occupancy issued by the building codes agency having jurisdiction that indicates the intended occupancy classification and construction type.

(12) CONFIRMATION OF LICENSURE. The applicant, before admitting any resident into the facility, must receive a written confirmation of licensure issued by the Department.

Stat. Auth.: ORS 410.070 & 443.450

Stats. Implemented: ORS 443.400 - 443.455 & 443.991

Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; SPD 16-2008, f. 12-31-08, cert. ef. 1-1-09; SPD 24-2010(Temp), f. & cert. ef. 10-5-10 thru 4-2-11; SPD 7-2011, f. 3-31-11, cert. ef. 4-1-11; SPD 11-2012, f. 8-31-12, cert. ef. 9-1-12; APD 1-2015, f. 1-14-15, cert. ef. 1-15-15; APD 26-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0025
Facility Administration

(1) FACILITY OPERATION.

(a) The licensee is responsible for the operation of the facility and the quality of services rendered in the facility.

(b) The licensee is responsible for the supervision, training, and overall conduct of staff when staff are acting within the scope of his or her employment duties.

(c) The licensee is responsible for ensuring that the facility complies with the tuberculosis screening recommendations in OAR 333-019-0041.

(d) The licensee is responsible for obtaining background checks on all subject individuals.

(2) BACKGROUND CHECK REQUIREMENTS.

(a) Background checks must be submitted to the Department for a criminal fitness determination on all subject individuals in accordance with OAR chapter 407-007-0200 to 407-007-0370, and 407-007-0600 to 0640, including before a subject individual's change in position.

(A) On or after July 28, 2009, no individual may be a licensee, or employed in any capacity in a facility, who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(B) Subject individuals who are employees and hired before July 28, 2009 are exempt from subsection (a) of this section provided that the employee remains in the same position working for the same employer after July 28, 2009. This exemption is not applicable to licensees.

(C) Background checks are to be completed every two years on all subject individuals.

(b) PORTABILITY OF BACKGROUND CHECK APPROVAL. A subject individual may be approved to work in multiple facilities under the same operational entity. The Department's Background Check Request form must be completed by the subject individual to show intent to work at various facilities.

(3) EMPLOYMENT APPLICATION. An application for employment in any capacity at a facility must include a question asking whether the applicant has been found to have committed abuse. The licensee must check all potential employees against the Oregon State Board of Nursing (Board) and inquire whether the individual is licensed or certified by the Board and whether there has been any disciplinary action by the Board against the individual or any substantiated abuse findings against a nursing assistant.

(4) Reasonable precautions must be exercised against any condition that may threaten the health, safety, or welfare of residents.

(5) REQUIRED POSTINGS. Required postings must be posted in a routinely accessible and conspicuous location to residents and visitors and must be available for inspection at all times. The licensee is responsible for posting the following:

(a) Facility license.

(b) The name of the administrator or designee in charge. The designee in charge must be posted by shift or whenever the administrator is out of the facility.

(c) The current facility staffing plan.

(d) A copy of the most recent re-licensure survey, including all revisits and plans of correction as applicable.

(e) The Ombudsman Notification Poster.

(f) Other notices relevant to residents or visitors required by state or federal law.

(6) NOTIFICATION. The facility must notify the Department's Central Office immediately by telephone, fax, or email, (if telephone communication is used the facility must follow-up within 72 hours by written or electronic confirmation) of the following:

(a) Any change of the administrator of record.

(b) Severe interruption of physical plant services where the health or safety of residents is endangered, such as the provision of heat, light, power, water, or food.

(c) Occurrence of epidemic disease in the facility. The facility must also notify the Local Public Health Authority as applicable.

(d) Facility fire or any catastrophic event that requires residents to be evacuated from the facility.

(e) Unusual resident death or suicide.

(f) A resident who has eloped from the facility and has not been found within 24 hours.

(7) POLICIES AND PROCEDURES. The facility must develop and implement written policies and procedures that promote high quality services, health and safety for residents, and incorporate the community-based care principles of individuality, independence, dignity, privacy, choice, and a homelike environment. The facility must develop and implement:

(a) A policy on the possession of firearms and ammunition within the facility. The policy must be disclosed in writing and by one other means of communication commonly used by the resident or potential resident in his or her daily living.

(b) A written policy that prohibits sexual relations between any facility employee and a resident who did not have a pre-existing relationship.

(c) Effective methods of responding to and resolving resident complaints.

(d) All additional requirements for written policies and procedures as established in OAR 411-054-0012 (Requirements for New Construction or Initial Licensure), OAR 411-054-0040 (Change of Condition and Monitoring), OAR 411-054-0045 (Resident Health Services), and OAR 411-054-0085 (Refunds and Financial Management).

(e) A policy on smoking.

(A) The smoking policy must be in accordance with:

(i) The Oregon Indoor Clean Air Act, ORS 433.835 to 433.875;

(ii) The rules in OAR chapter 333, division 015; and

(iii) Any other applicable state and local laws.

(B) The facility may designate itself as non-smoking.

(f) A policy for the referral of residents who may be victims of acute sexual assault to the nearest trained sexual assault examiner. The policy must include information regarding the collection of medical and forensic evidence that must be obtained within 86 hours of the incident.

(g) A policy on facility employees not receiving gifts or money from residents.

(8) RECORDS. The facility must ensure the preparation, completeness, accuracy, and preservation of resident records.

(a) The facility must develop and implement a written policy that prohibits the falsification of records.

(b) Resident records must be kept for a minimum of three years after the resident is no longer in the facility.

(c) Upon closure of a facility, the licensee must provide the Department with written notification of the location of all records.

(9) QUALITY IMPROVEMENT PROGRAM. The facility must develop and conduct an ongoing quality improvement program that evaluates services, resident outcomes, and resident satisfaction.

(10) DISCLOSURE - RESIDENCY AGREEMENT. The facility must provide a Department designated Uniform Disclosure Statement (form SDS 9098A) to each individual who requests information about the facility. The residency agreement and the disclosure information described in subsection (a) of this section must be provided to all potential residents before move-in. All disclosure information and residency agreements must be written in compliance with these rules.

(a) The residency agreement and the following disclosure information must be reviewed by the Department before distribution and must include the following:

(A) Terms of occupancy, including policy on the possession of firearms and ammunition.

(B) Payment provisions including the basic rental rate and what it includes, cost of additional services, billing method, payment system and due dates, deposits, and non-refundable fees, if applicable.

(C) The method for evaluating a resident's service needs and assessing the costs for the services provided.

(D) Policy for increases, additions, or changes to the rate structure. The disclosure must address the minimum requirement of 30 days prior written notice of any facility-wide increases or changes and the requirement for immediate written notice for individual resident rate changes that occur as a result of changes in the service plan.

(E) Refund and proration conditions.

(F) A description of the scope of resident services available according to OAR 411-054-0030.

(G) A description of the service planning process.

(H) Additional available services.

(I) The philosophy of how health care and ADL services are provided to the resident.

(J) Resident rights and responsibilities.

(K) The facility's system for packaging medications including the option for residents to choose a pharmacy that meets the requirements of ORS 443.437.

(L) Criteria, actions, circumstances, or conditions that may result in a move-out notification or intra-facility move.

(M) Resident rights pertaining to notification of involuntary move-out.

(N) Notice that the Department has the authority to examine resident records as part of the evaluation of the facility.

(O) The facility's staffing plan.

(P) Additional elements as listed in 411-054-0027 (2).

(b) The facility may not include any provision in the residency agreement or disclosure information that is in conflict with these rules and may not ask or require a resident to waive any of the resident's rights or the facility's liability for negligence.

(c) The facility must retain a copy of the original and any subsequent signed and dated residency agreements and must provide copies to the resident or to the resident's designated representative.

(d) The facility must give residents 30 days prior written notice of any additions or changes to the residency agreement. Changes to the residency agreement must be faxed, emailed, or mailed to the Department before distribution.

Stat. Auth.: ORS 181.534, 410.070, 443.004 & 443.450
Stats. Implemented: ORS 181.534, 443.004, 443.400 - 443.455 & 443.991
Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; SPD 13-2009, f. 9-30-09, cert. ef. 10-1-09; SPD 23-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 1-2010(Temp), f. & cert. ef. 3-11-10 thru 6-30-10; SPD 10-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 11-2012, f. 8-31-12, cert. ef. 9-1-12; APD 26-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0027
Resident Rights and Protections

(1) The facility must implement a residents' Bill of Rights. Each resident and the resident's designated representative, if appropriate, must be given a copy of the resident's rights and responsibilities before moving into the facility. The Bill of Rights must state that residents have the right:

(a) To be treated with dignity and respect.

(b) To be given informed choice and opportunity to select or refuse service and to accept responsibility for the consequences.

(c) To participate in the development of their initial service plan and any revisions or updates at the time those changes are made.

(d) To receive information about the method for evaluating their service needs and assessing costs for the services provided.

(e) To exercise individual rights that do not infringe upon the rights or safety of others.

(f) To be free from neglect, financial exploitation, verbal, mental, physical, or sexual abuse.

(g) To receive services in a manner that protects privacy and dignity.

(h) To have prompt access to review all of their records and to purchase photocopies. Photocopied records must be promptly provided, but in no case require more than two business days (excluding Saturday, Sunday, and holidays).

(i) To have medical and other records kept confidential except as otherwise provided by law.

(j) To associate and communicate privately with any individual of choice, to send and receive personal mail unopened, and to have reasonable access to the private use of a telephone.

(k) To be free from physical restraints and inappropriate use of psychoactive medications.

(l) To manage personal financial affairs unless legally restricted.

(m) To have access to, and participate in, social activities.

(n) To be encouraged and assisted to exercise rights as a citizen.

(o) To be free of any written contract or agreement language with the facility that purports to waive their rights or the facility's liability for negligence.

(p) To voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of retaliation.

(q) To be free of retaliation after they have exercised their rights provided by law or rule.

(r) To have a safe and homelike environment.

(s) To be free of discrimination in regard to race, color, national origin, gender, sexual orientation, or religion.

(t) To receive proper notification if requested to move-out of the facility, and to be required to move-out only for reasons stated in OAR 411-054-0080 (Involuntary Move-out Criteria) and have the opportunity for an administrative hearing, if applicable.

(2) HCBS RIGHTS.

(a) Effective January 1, 2016 for providers initially licensed after January 1, 2016, and effective no later than September 1, 2018 for providers initially licensed before January 1, 2016 the following rights must include the freedoms authorized by 42 CFR 441.301(c)(4) & 42 CFR 441.530(a)(1):

(A) Live under a legally enforceable residency agreement;

(B) The freedom and support to access food at any time;

(C) To have visitors of the resident's choosing at any time;

(D) Choose a roommate when sharing a bedroom;

(E) Furnish and decorate the resident's bedroom according to the Residency Agreement; and

(F) The freedom and support to control the resident's schedule and activities.

(b) The rights described in (B) through (F) of this section must meet the requirements set forth in OAR 411-054-0038 and shall not be limited without the informed, written consent of the resident or the resident's representative, and approved by the person-centered service plan coordinator.

(3) Licensees and facility personnel may not act as a resident's guardian, conservator, trustee, or attorney-in-fact unless related by birth, marriage, or adoption to the resident, as follows, parent, child, brother, sister, grandparent, grandchild, aunt or uncle, or niece or nephew. An owner, administrator, or employee may act as a representative payee for the resident or serve in other roles as provided by law.

(4) Licensees and facility personnel may not spend resident funds without the resident's consent.

(a) If the resident is not capable of consenting, the resident's representative must give consent.

(b) If the resident has no representative and is not capable of consenting, licensees and facility personnel must follow the requirements described in OAR 411-054-0085 and may not spend resident funds for items or services that are not for the exclusive benefit of the resident.

Stat. Auth.: ORS 410.070 & 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991
Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; SPD 11-2012, f. 8-31-12, cert. ef. 9-1-12; APD 26-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0034
Resident Move-In and Evaluation

(1) INITIAL SCREENING AND MOVE-IN.

(a) The facility must determine whether a potential resident meets the facility's admission requirements.

(b) Before the resident moving in, the facility must conduct an initial screening to determine the prospective resident's service needs and preferences. The screening must determine the ability of the facility to meet the potential resident's needs and preferences, while considering the needs of the other residents and the facility's overall service capability.

(c) Each resident record must, before move-in and when updated, include the following information:

(A) Prior living arrangements;

(B) Emergency contacts;

(C) Service plan involvement - resident, family, and social supports;

(D) Financial and other legal relationships, if applicable, including, but not limited to:

(i) Advance directives;

(ii) Guardianship;

(iii) Conservatorship; and

(iv) Power of attorney.

(E) Primary language;

(F) Community connections; and

(G) Health and social service providers.

(2) RESIDENT EVALUATION - GENERAL. The resident evaluation is the foundation that a facility uses to develop the service plan and reflects the resident's current health and mental status. The evaluation information may be collected using tools and protocols established by the facility, but must contain the elements stated in this rule.

(a) Resident evaluations must be:

(A) Performed before the resident moves into the facility, with updates and changes as appropriate within the first 30 days; and

(B) Performed at least quarterly, to correspond with the quarterly service plan updates.

(C) Reviewed and any updates must be documented each time a resident has a significant change in condition.

(D) Done in person and the facility must gather data that is relevant to the needs and current condition of the resident.

(E) Documented, dated, and indicate who was involved in the evaluation process.

(b) 24 months of past evaluations must be kept in the resident's files in an accessible, on-site location.

(c) The facility administrator is responsible for assuring only trained and experienced staff perform resident evaluations.

(3) EVALUATION REQUIREMENTS AT MOVE-IN.

(a) The resident evaluation must be completed before the resident moves into the facility. This evaluation provides baseline information of the resident's physical and mental condition at move-in.

(b) If there is an urgent need and the evaluation is not completed before move-in, the facility must document the reasons and complete the evaluation within eight hours of move-in.

(c) The initial evaluation must contain the elements specified in section (5) of this rule, and address sufficient information to develop an initial service plan to meet the resident's needs.

(d) The initial evaluation must be updated and modified as needed during the 30 days following the resident's move into the facility.

(e) After the initial 30 day move-in period, the initial evaluation must be retained in the resident's file for 24 months. Future evaluations must be separate and distinct from the initial evaluation.

(4) QUARTERLY EVALUATION REQUIREMENTS.

(a) Resident evaluations must be performed quarterly after the resident moves into the facility.

(b) The quarterly evaluation is the basis of the resident's quarterly service plan.

(c) The most recent quarterly evaluation, with documented change of condition updates, must be in the resident's current record and available to staff.

(d) If the evaluation is revised and updated at the quarterly review, changes must be dated and initialed and prior historical information must be maintained.

(5) The resident evaluation must address the following elements:

(a) Resident routines and preferences including:

(A) Customary routines - sleep, dietary, social, and leisure;

(B) Spiritual, cultural preferences; and

(C) Additional elements as listed in 411-054-0027(2).

(b) Physical health status including:

(A) List of current diagnoses;

(B) List of medications and PRN use;

(C) Visits to health practitioners, emergency room, hospital, or nursing facility in the past year; and

(D) Vital signs if indicated by diagnoses, health problems, or medications.

(c) Mental health issues including:

(A) Presence of depression, thought disorders, or behavioral or mood problems;

(B) History of treatment; and

(C) Effective non drug interventions.

(d) Cognition, including:

(A) Memory;

(B) Orientation;

(C) Confusion; and

(D) Decision making abilities.

(e) Communication and sensory including:

(A) Hearing;

(B) Vision;

(C) Speech;

(D) Assistive devices; and

(E) Ability to understand and be understood.

(f) Activities of daily living including:

(A) Toileting, bowel, and bladder management;

(B) Dressing, grooming, bathing, and personal hygiene;

(C) Mobility ambulation, transfers, and assistive devices; and

(D) Eating, dental status, and assistive devices.

(g) Independent activities of daily living including:

(A) Ability to manage medications;

(B) Ability to use call system;

(C) Housework and laundry; and

(D) Transportation.

(h) Pain pharmaceutical and non-pharmaceutical interventions.

(i) Skin condition.

(j) Nutrition habits, fluid preferences, and weight if indicated.

(k) List of treatments type, frequency, and level of assistance needed.

(l) Indicators of nursing needs, including potential for delegated nursing tasks.

(m) Review of risk indicators including:

(A) Fall risk or history;

(B) Emergency evacuation ability;

(C) Complex medication regimen;

(D) History of dehydration or unexplained weight loss or gain;

(E) Recent losses;

(F) Unsuccessful prior placements;

(G) Elopement risk or history;

(H) Smoking. The resident's ability to smoke without causing burns or injury to themselves or others or damage to property must be evaluated and addressed in the resident's service plan; and

(I) Alcohol and drug use. The resident's use of alcohol or the use of drugs not prescribed by a physician must be evaluated and addressed in the resident's service plan.

(6) If the information has not changed from the previous evaluation period, the information does not need to be repeated. A dated and initialed notation of no changes is sufficient. The prior evaluation must then be kept in the current resident record for reference.

Stat. Auth.: ORS 410.070 & 443.450

Stats. Implemented: ORS 443.400 - 443.455, 443.991

Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; SPD 13-2009, f. 9-30-09, cert. ef. 10-1-09; SPD 11-2012, f. 8-31-12, cert. ef. 9-1-12; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0036

Service Plan — General

(1) If the resident has a Person-Centered Service Plan pursuant to 411-004-0030, the facility must incorporate all elements identified in the person-centered service plan into the resident's service plan.

(2) SERVICE PLAN. The service plan must reflect the resident's needs as identified in the evaluation and include resident preferences that support the principles of dignity, privacy, choice, individuality, and independence.

(a) The service plan must be completed:

(A) Before resident move-in, with updates and changes as appropriate within the first 30-days; and

(B) Following quarterly evaluations.

(b) The service plan must be readily available to staff and provide clear direction regarding the delivery of services.

(c) The service plan must include a written description of who shall provide the services and what, when, how, and how often the services shall be provided.

(d) Changes and entries made to the service plan must be dated and initialed.

(e) When the resident experiences a significant change of condition the service plan must be reviewed and updated as needed.

(f) A copy of the service plan, including each update, must be offered to the resident or to the resident's legal representative.

(g) The facility administrator is responsible for ensuring the implementation of services.

(3) SERVICE PLAN REQUIREMENTS BEFORE MOVE-IN.

(a) Based on the resident evaluation performed before move-in, an initial service plan must be developed before move-in that reflects the identified needs and preferences of the resident.

(b) The initial service plan must be reviewed within 30-days of move-in to ensure that any changes made to the plan during the initial 30- days, accurately reflect the resident's needs and preferences.

(c) Staff must document and date adjustments or changes as applicable.

(4) QUARTERLY SERVICE PLAN REQUIREMENTS.

(a) Service plans must be completed quarterly after the resident moves into the facility.

(b) The quarterly evaluation is the basis of the resident's quarterly service plan.

(c) If the resident's service plan is revised and updated at the quarterly review, changes must be dated and initialed, and prior historical information must be maintained.

(5) SERVICE PLANNING TEAM. The service plan must be developed by a Service Planning Team that consists of the resident, the resident's legal representative, if applicable, any person of the resident's choice, the facility administrator or designee and at least one other staff person who is familiar with, or who is going to provide services to the resident. Involved family members and case managers must be notified in advance of the service-planning meeting.

(a) As applicable, the Service Planning Team must also include:

(A) Local APD or AAA case managers and family invited by the resident, as available.

(B) A licensed nurse if the resident shall need, or is receiving nursing services or experiences a significant change of condition as required in 411-054-0045(1)(f)(D) (Resident Health Services).

(C) The resident's physician or other health practitioner.

(b) Each resident must actively participate in the development of the service plan to the extent of the resident's ability and willingness to do so. If resident participation is not possible, documentation must reflect the facility's attempts to determine the resident's preferences.

(6) RISK AGREEMENT. When a resident's actions or choices pose a potential risk to that resident's health or well-being, the facility may utilize a risk agreement to explore alternatives and potential consequences with the resident.

(a) The facility must identify the need for and develop a written risk agreement following the facility's established guidelines and procedures. A risk agreement must include:

(A) An explanation of the cause of concern;

(B) The possible negative consequences to the resident or others;

(C) A description of the resident's preference;

(D) Possible alternatives or interventions to minimize the potential risks associated with the resident's current preferences and actions;

(E) A description of the services the facility shall provide to accommodate the residents' choice or minimize the potential risk; and

(F) The final agreement, if any, reached by all involved parties, must be included in the service plan.

(b) The licensing policy analyst must be consulted and alternatives reviewed before the resident signs the agreement.

(c) The facility must involve the resident, the resident's designated representative, and others as indicated, to develop, implement, and review the risk agreement. The resident's preferences shall take precedence over those of a family member.

(d) A risk agreement shall not be entered into or continued with, or on behalf of, a resident who is unable to recognize the consequences of their behavior or choices.

(e) The risk agreement must be reviewed at least quarterly.

Stat. Auth.: ORS 410.070 & 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991
Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; APD 26-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0038
Individually-Based Limitations

This rule will begin being implemented January 1, 2017. The requirements in this rule must be in place no later than February 28, 2018.

(1) When threats to the health and safety of an individual or others arise, limitations may be applied in the following areas:

(a) To have unit entrance doors lockable by the individual, with only appropriate staff having a key to access the unit.

(b) For individuals sharing units, to have a choice of roommates.

(c) To have the freedom to decorate and furnish his or her own unit as agreed to within the Residency Agreement.

(d) To have visitors of his or her choosing at any time.

(e) To have the freedom and support to control his or her own schedule and activities.

(f) To have the freedom and support to have access to food at any time.

(2) An individually-based limitation must be supported by a specific assessed need and documented in the person-centered service plan by completing and signing a program approved form documenting the consent to the appropriate limitation. The form identifies and documents:

(a) The specific and individualized assessed need justifying the individually-based limitation;

(b) The positive interventions and supports used prior to any individually-based limitation;

(c) Less intrusive methods that have been tried but did not work;

(d) A clear description of the limitation that is directly proportionate to the specific assessed need;

(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation;

(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually;

(g) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative; and

(h) An assurance that the interventions and support do not cause harm to the individual.

(3) Providers are responsible for:

(a) Maintaining a copy of the completed and signed form documenting the consent to the appropriate limitation. The form must be signed by the individual, or, if applicable, the legal representative of the individual prior to the implementation being implemented;

(b) Regular collection and review of data to measure the ongoing effectiveness of and the continued need for the individually-based limitation; and

(c) Requesting a review of the individually-based limitation when a new individually-based limitation is indicated, or change or removal of an individually-based limitation is needed.

Stat. Auth.: ORS 409.050, 413.042, 413.085
Stats. Implemented: ORS 409.050, 413.042, 413.085
Hist.: APD 26-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0065
Administrator Qualifications and Requirements

(1) FULL-TIME ADMINISTRATOR. Each licensed residential care and assisted living facility must employ a full-time administrator. The administrator must be scheduled to be on-site in the facility at least 40 hours per week.

(2) ADMINISTRATOR QUALIFICATIONS. The administrator must:

(a) Be at least 21 years of age:

(b) Possess a high school diploma or equivalent; and

(A) Have at least two years professional or management experience that has occurred within the last five years, in a health or social service related field or program, or have a combination of experience and education; or

(B) Possess an accredited Bachelor's Degree in a health or social service related field.

(3) ADMINISTRATOR REQUIREMENTS.

(a) Facility administrators must meet the following training requirements before employment:

(A) Complete a Department approved classroom administrator training program of at least 40 hours;

(B) Complete a Department approved administrator training program that includes both a classroom training of less than 40 hours and a Department approved 40-hour internship program with a Department approved administrator; or

(C) Complete another Department approved administrator training program.

(b) CONTINUING EDUCATION. Administrators must have 20 hours of documented Department approved continuing education credits each year. The approved administrator training program fulfills the 20-hour continuing education requirement for the first year.

(c) Persons who have met Department approved training program requirements, but have been absent from an administrator position for five years or less, do not have to re-take the administrator training, but must provide evidence of 20 hours of annual continuing education.

(d) Before employment as a facility administrator, persons must complete the criminal records check requirements in OAR 407-007-0200 to 407-007-0370 and comply with the tuberculosis screening recommendations in OAR 333-019-0041. An administrator of a facility may not have convictions of any of the crimes described in OAR 407-007-0275.

(e) ADMINISTRATOR REFERENCE SUMMARY. Newly hired administrators are responsible for the completion of form SDS 0566, Administrator Reference Summary, and are required to email or fax the

completed form to the Department upon hire. The Department may reject a form that has been falsified or is incomplete.

(f) DESIGNEE. The administrator must appoint a staff member as designee to oversee the operation of the facility in the administrator's absence. The administrator, or a designee, must at all times:

(A) Be in charge on-site;

(B) Ensure there are sufficient, qualified staff; and

(C) Ensure the care, health, and safety needs of the residents are met.

(4) ADMINISTRATOR TRAINING COURSE STANDARDS.

(a) The training curriculum for the administrator training course must be approved by the Department and shall be re-evaluated by the Department at periodic intervals.

(b) Individuals, companies, or organizations providing the administrator training course must be approved by the Department. The Department may withdraw approval under the following conditions:

(A) Failure to follow Department approved curriculum;

(B) The trainer demonstrates lack of competency in training;

(C) There is insufficient frequency of training to meet the need; or

(D) Facilities owned or operated by the training entity have a pattern of substantial non-compliance with these rules.

(c) Approved training must be open and available to all applicants and may not be used to orient trainees to a specific company's management or operating procedures.

Stat. Auth.: ORS 410.070 & 443.450

Stats. Implemented: ORS 443.400 - 443.455, 443.991

Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; SPD 23-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 10-2010, f. 6-30-10, cert. ef. 7-1-10; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0080

Involuntary Move-out Criteria

The Department of Human Services, Aging and People with Disabilities Office encourages facilities to support a resident's choice to remain in his or her living environment while recognizing that some residents may no longer be appropriate for the community-based care setting due to safety and medical limitations.

(1) Information must be specified in the facility's disclosure information that describes the types of health, nursing, behavior, and care services the facility is unable to provide. The minimum required services identified in OAR 411-054-0030 (Resident Services) must be provided before a resident may be asked to move-out. In addition, facilities indorsed under OAR chapter 411, division 057 (Indorsement of Alzheimer's Care Units) must provide services to support residents with the progressive symptoms of the disease.

(2) The facility must give written notification on form SDS 0567 to the resident, the resident's legal representative, and case manager, if applicable, when the facility requests a resident to move from the facility. The resident must be given 30 days advance written notice to move from the facility unless criteria in section (6) of this rule are met.

(3) The facility must demonstrate through service plan modification and documentation, attempts to resolve the reason for the move-out.

(4) A resident may be asked to move from a facility if one or more of the following circumstances exists:

(a) The resident's needs exceed the level of ADL services the facility provides as specified in the facility's disclosure information;

(b) The resident engages in behavior or actions that repeatedly and substantially interferes with the rights, health, or safety of residents or others;

(c) The resident has a medical or nursing condition that is complex, unstable or unpredictable, and exceeds the level of health services the facility provides as specified in the facility's disclosure information;

(d) The facility is unable to accomplish resident evacuation in accordance with OAR 411-054-0090 (Fire and Life Safety);

(e) The resident exhibits behavior that poses a danger to self or others;

(f) The resident engages in illegal drug use, or commits a criminal act that causes potential harm to the resident or others; or

(g) Non-payment of charges.

(5) The facility must fax or email a copy of the move-out notice to the Department's central office in Salem. Where a resident lacks capacity and there is no legal representative, a copy of the notice to move-out must be emailed or faxed to the State Long-Term Care Ombudsman who may request an informal conference and administrative hearing for the resident.

(6) LESS THAN 30-DAY NOTICE. The resident must be given 30 days advance written notice before being moved from the facility, except in the following unusual circumstances:

(a) A resident who leaves the facility to receive urgent medical or psychiatric care may return to the facility unless, at the time the resident is to return, facility staff have re-evaluated the resident's needs and have determined that the facility is unable to meet the resident's needs.

(A) An appropriate facility staff person must re-evaluate the resident's condition before determining the facility is unable to meet the resident's needs.

(B) A written notice on form SDS 0568 must be given to the resident or the resident's legal representative on the date the facility makes its determination. The written notice shall contain the specific reasons the facility is unable to meet the resident's needs, as determined by the facility's evaluation.

(C) If the resident or resident's designee requests an administrative hearing, the facility must hold the resident's room or unit and may charge room and board payment pending resolution of the administrative hearing.

(b) If the health or safety of the resident or others is in jeopardy and undue delay in moving the resident increases the risk of harm, the facility may give less than 30 days advance written notice on form SDS 0568.

(A) The Department's central office in Salem must be consulted and alternatives reviewed before the resident receives the notice.

(B) The resident is entitled to request an administrative hearing, as stated in section (7) of this rule.

(C) If the resident is moved out of the facility and requests an administrative hearing, the facility must hold the resident's room, without charge for room and board or services, pending resolution of the administrative hearing.

(c) The facility must fax or email a copy of the move-out notice to the Department's central office in Salem and the State Long-Term Care Ombudsman Office on the same day the notice is delivered to the resident or the resident's legal representative.

(7) ADMINISTRATIVE HEARING. Except when a facility has had its license revoked, not renewed, voluntarily surrendered, or terminates its Medicaid contract, a resident who receives an involuntary move-out notice is entitled to an administrative hearing, provided the resident or resident's designee requests a hearing in a timely manner.

(a) A resident who receives a 30-day notice to move has 10 working days to request an administrative hearing after receipt of the notice. The Department's central office in Salem must be notified of all hearing requests.

(b) The Department's central office in Salem shall notify the Office of Administrative Hearings of the resident's request for a formal administrative hearing.

(c) The Department may hold an informal conference to resolve the matter without a formal hearing. If a resolution is reached at the informal conference, no formal hearing shall be held.

(d) A resident who is not allowed to return to the facility after receiving medical or psychiatric care, or who is immediately moved out of the facility to protect the health or safety of the resident or others, as specified in section (6) of this rule, has five working days to request an administrative hearing after receiving the move-out notice.

(A) The Department's central office in Salem must be notified by telephone, email, or fax of a resident's request for hearing.

(B) When the resident is not allowed to remain in the facility, the Department's central office in Salem shall request an expedited administrative hearing.

(e) The facility may not rent the resident's unit pending resolution of the administrative hearing.

(8) A resident who was admitted January 1, 2006 or later may be moved without advance notice if all of the following are met:

(a) The facility was not notified before admission that the resident is on probation, parole, or post-prison supervision after being convicted of a sex crime.

(b) The facility learns the resident is on probation, parole, or post-prison supervision after being convicted of a sex crime.

(c) The resident presents a current risk of harm to another resident, staff, or visitor in the facility, as evidenced by:

(A) Current or recent sexual inappropriateness, aggressive behavior of a sexual nature, or verbal threats of a sexual nature; or

(B) Current communication from the State Board of Parole and Post-Prison Supervision, Department of Corrections, or community corrections agency parole or probation officer that the individual's Static 99 score or other assessment indicates a probable sexual re-offense risk to others in the facility.

(d) Before the move, the facility must contact the Department's central office in Salem by telephone and review the criteria in sections

(8)(c)(A) and (B) of this rule. The Department shall respond within one working day of contact by the facility. The Department of Corrections parole or probation officer must be included in the review, if available. The Department shall advise the facility if rule criteria for immediate move-out are not met. DHS shall assist in locating placement options.

(e) A written move-out notice must be completed on form SDS 0568A. The form must be filled out in its entirety and a copy of the notice delivered in person, to the resident, or the resident's legal representative, if applicable. Where a person lacks capacity and there is no legal representative, a copy of the notice to move-out shall be immediately faxed or emailed to the State Long Term Care Ombudsman.

(f) Before the move, the facility shall orally review the notice and right to object with the resident or legal representative and determine if a hearing is requested. A request for hearing does not delay the involuntary move-out. The facility shall immediately telephone the Department's central office in Salem when a hearing is requested. The hearing shall be held within five business days of the resident's move. No informal conference shall be held before the hearing.

Stat. Auth.: ORS 410.070 & 443.450
Stats. Implemented: ORS 443.400 - 443.455, 443.991
Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

411-054-0120
Civil Penalties

(1) For purposes of imposing civil penalties, facilities licensed under ORS 443.400 to 443.455 and subsection (2) of ORS 443.991 are considered to be long-term care facilities subject to ORS 441.705 to 441.745.

(2) For purposes of this rule, "person" means a licensee under ORS 443.420 or a person who the Department finds shall be so licensed but is not, but does not include any employee of such licensee or person.

(3) For purposes of this rule, "resident rights" means that each resident must be assured the same civil and human rights accorded to other citizens as described in OAR 411-054-0027.

(4) The Department shall exercise the powers under ORS 441.705 to 441.745 and thereby issues the following schedule of penalties applicable to residential care and assisted living facilities:

(a) A Class I violation exists when there is non-compliance involving direct resident care or feeding, adequate staff, or sanitation involving direct resident care or resident rights.

(b) The Department shall impose a civil penalty of not less than $2,500 for each occurrence of substantiated abuse that resulted in the death, serious injury, rape, or sexual abuse of a resident. The civil penalty may not exceed $15,000 in any 90-day period.

(A) To impose this civil penalty, the Department shall establish that:

(i) The abuse arose from deliberate or other than accidental action or inaction;

(ii) The conduct resulting in the abuse was likely to cause death, serious injury, rape, or sexual abuse of a resident; and

(iii) The person substantiated for the abuse had a duty of care toward the resident.

(B) For the purposes of this civil penalty, the following definitions apply:

(i) "Serious injury" means a physical injury that creates a substantial risk of death or that causes serious disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.

(ii) "Rape" means rape in the first, second, or third degree as described in ORS 163.355, 163.365, and 163.375.

(iii) "Sexual Abuse" means abuse as defined under ORS 443.455.

(iv) "Other than accidental" means failure on the part of the licensee, or licensee's employees, agents, or volunteers for whose conduct the licensee is responsible, to comply with applicable Oregon Administrative Rules.

(c) A Class II violation exists when there is non-compliance with the license requirements relating to a license required, the license requirements relating to administrative management, or personal care services and activities. Class II violations may result in imposition of a fine for violations found on two consecutive monitorings of the facility.

(d) A Class III violation exists when there is non-compliance with the license requirements relating to building requirements and resident furnishings. Class III violations may result in imposition of a fine for violations found on two consecutive monitorings of the facility.

(5) For purposes of this rule, a monitoring occurs when a residential care or assisted living facility is surveyed, inspected, or investigated by an employee or designee of the Department or an employee or designee of the State Fire Marshal.

(6) In imposing a penalty pursuant to section (4) of this rule, the Department shall consider the following factors:

(a) The past history of the person incurring a penalty in taking all feasible steps or procedures necessary or appropriate to correct any violation;

(b) Any prior violations of statutes or rules pertaining to residential care or assisted living facilities;

(c) The economic and financial conditions of the person incurring the penalty; and

(d) The immediacy and extent the violation threatens the health, safety, and well being of residents.

(7) Any civil penalty imposed under ORS 443.455 and 441.710 shall become due and payable when the person incurring the penalty receives a notice in writing from the Department. The notice shall be sent by registered or certified mail and shall include:

(a) A reference to the particular sections of the statute, rule, standard, or order involved;

(b) A short and plain statement of the matters asserted or charged;

(c) A statement of the amount of the penalty or penalties imposed; and

(d) A statement of the party's right to request a hearing.

(8) The person to whom the notice is addressed shall have 10 days from the date of postmark to make written application for a hearing before the Department.

(9) All hearings shall be conducted pursuant to the applicable provisions of ORS chapter 183.

(10) If the person notified fails to request a hearing within 10 days, an order may be entered by the Department assessing a civil penalty.

(11) If, after a hearing, the person is found to be in violation of a license, rule, or order listed in ORS 441.710(1), an order may be entered by the Department assessing a civil penalty.

(12) A civil penalty imposed under ORS 443.455 or 441.710 may be remitted or reduced upon such terms and conditions as the Department considers proper and consistent with the public health and safety.

(13) If the order is not appealed, the amount of the penalty is payable within 10 days after the order is entered. If the order is appealed and is sustained, the amount of the penalty is payable within 10 days after the court decision. The order, if not appealed or sustained on appeal, shall constitute a judgment and may be filed in accordance with the provisions of ORS 18.005 to 18.428. Execution may be issued upon the order in the same manner as execution upon a judgment of a court of record.

(14) A violation of any general order or final order pertaining to a residential care or assisted living facility issued by the Department is subject to a civil penalty in the amount of not less than $5 and not more than $500 for each and every violation.

(15) Judicial review of civil penalties imposed under ORS 441.710 shall be as provided under ORS 183.480, except that the court may, in its discretion, reduce the amount of the penalty.

(16) All penalties recovered under ORS 443.455 and 441.710 to 441.740 shall be paid to the Quality Care Fund.

Stat. Auth.: ORS 410.070 & 443.450
Stats. Implemented: ORS 441.705 - 441.745, 443.400 - 443.455 & 443.991
Hist.: SPD 14-2007, f. 8-31-07, cert. ef. 11-1-07; SPD 23-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 10-2010, f. 6-30-10, cert. ef. 7-1-10; APD 3-2015(Temp), f. & cert. ef. 1-29-15 thru 7-27-15; APD 14-2015, f. 6-24-15, cert. ef. 6-28-15; APD 10-2016, f. 6-27-16, cert. ef. 6-28-16

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Rule Caption: Individually-Based Limitations Implementation Date Change
Adm. Order No.: APD 11-2016(Temp)
Filed with Sec. of State: 6-27-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 411-004-0040
Subject: OAR 411-004-0040 is being amended to delay the initial effective date of the rule by six months. The Department needs to immediately amend the rules to change the effective date and allow stakeholders, providers, and state and county employees additional time to prepare for implementation of the rule.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-004-0040
Individually-Based Limitations

This rule will begin being implemented January 1, 2017. The requirements in this rule must be in place no later than February 28, 2018.

(1) When conditions under OAR 411-004-0020(2)(d) to (2)(j) may not be met due to threats to the health and safety of an individual or others, provider owned, controlled, or operated residential settings must apply individually-based limitations as described in this rule.

(2) An individually-based limitation must be supported by a specific assessed need and documented in the person-centered service plan by completing and signing a program approved form documenting the consent to the appropriate limitation. The form identifies and documents:

(a) The specific and individualized assessed need justifying the individually-based limitation;

(b) The positive interventions and supports used prior to any individually-based limitation;

(c) Less intrusive methods that have been tried but did not work;

(d) A clear description of the limitation that is directly proportionate to the specific assessed need;

(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation;

(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually;

(g) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative; and

(h) An assurance that the interventions and support do not cause harm to the individual.

(3) Providers are responsible for:

(a) Maintaining a copy of the completed and signed form documenting the consent to the appropriate limitation. The form must be signed by the individual, or, if applicable, the legal representative of the individual;

(b) Regular collection and review of data to measure the ongoing effectiveness of and the continued need for the individually-based limitation; and

(c) Requesting a review of the individually-based limitation when a new individually-based limitation is indicated, or change or removal of an individually-based limitation is needed.

Stat. Auth.: ORS 409.050, 413.042, 413.085
Stats. Implemented: ORS 409.050, 413.042, 413.085
Hist.: APD 23-2015,f. 12-15-15, cert. ef. 1-1-16; APD 11-2016(Temp), f. 6-27-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: In-Home Services
Adm. Order No.: APD 12-2016(Temp)
Filed with Sec. of State: 6-27-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 411-030-0068, 411-030-0070
Subject: The Department of Human Services (Department) is immediately amending OAR 411-030 to:

- Limit live-in services to individuals currently receiving the service.
- Add qualifications to receive a differential rate for homecare workers.
- Fix minor grammar, formatting, punctuation, and housekeeping issues in the rules.

These changes are effective July 1, 2016.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-030-0068
Live-In Services and Shift Services

(1) As of July 1, 2016, no individual may be approved to receive live-in services who did not receive live-in services on June 30, 2016.

(2) An individual is only eligible for shift services if the assessment determines the individual meets the criteria described in section (3) of this rule.

(3) Individuals with service plans that meet the definition of live-in services or shift services must meet subsections (a) and either (b) or (c) of this section of the rule.

(a) The provision of assistance with at least one ADL or IADL task must be required sometime during each hour the individual is awake in order to ensure the safety and well-being of the individual.

(b) The individual is assessed as full assist in mobility or elimination as defined in OAR 411-015-0006, and has at least one of the following conditions:

(A) A debilitating medical condition that includes, but is not limited to, any of the following symptoms:

(i) Cachexia;

(ii) Severe neuropathy;

(iii) Coma;

(iv) Persistent or reoccurring stage 3 or 4 wounds;

(v) Late stage cancer;

(vii) Frequent and unpredictable seizures; or

(viii) Debilitating muscle spasms.

(B) A spinal cord injury or similar disability with permanent impairment.

(C) An acute care or hospice need that is expected to last no more than six months.

(c) The individual is assessed as full assist in cognition as defined in OAR 411-015-0006 and meets all of the following criteria:

(A) A diagnosis of traumatic brain injury, dementia or a related disorder, or a debilitating mental health disorder that meets the criteria described in OAR 411-015-0015(2); and

(B) Has one of the following assessed needs as defined in OAR 411-015-0006:

(i) Full assist in danger to self or others.

(ii) Full assist in wandering.

(iii) Full assist in awareness.

(iv) Full assist in judgment.

(4) The following limitations apply:

(a) A homecare worker providing live-in services must be available to address the service needs of an eligible individual as they arise throughout an entire 24-hour period. A homecare worker is not providing live-in services if the homecare worker is outside the individual's home or building during the homecare worker's on-duty hours and the homecare worker engages in activities that are unrelated to the provision of the individual's ADL or IADL services and supports. A homecare worker is not providing live-in services if they are offsite and are not performing direct ADL or IADL services.

(b) Hourly services by another homecare worker or contracted in-home agency may be authorized in addition to live-in services for any task that requires more than one homecare worker to simultaneously perform the task, or to allow a live-in homecare worker to sleep for at least five continuous hours during a 24-hour work period.

(c) A homecare worker who is providing live-in services for an individual may not also provide hourly services for the same individual.

(5) Individuals who are receiving live-in services on June 30, 2016 may continue receiving live-in services until one of the following occurs:

(a) The individual moves from an in-home setting that does not meet the requirements of OAR 411-030-0033 for more than 30 days and later moves to an in-home setting that meets the requirements of OAR 411-030-0033.

(b) The individual ends his or her live-in services for more than 30 days.

(c) An assessment determines the individual does not meet the criteria described in section (3) of this rule.

(6) Individuals who currently receive live-in services for at least four days a week, or are receiving hours under live-in services in the Independent Choices Program, and who have been determined not to meet the criteria for live-in services per section (1) of this rule after an assessment created on or after August 31, 2015, may be granted an exception by central office under the following circumstances:

(a) The individual must be eligible for 159 hours of live-in services on the most recent assessment prior to August 31, 2015, and be assessed as meeting one of the following as defined in OAR 415-015-0006:

(A) Full assist in mobility and at least a substantial assist in ambulation or an assist in transfers.

(B) Full assist in cognition.

(C) Full assist in at least two ADLs under elimination.

(b) Exceptions granted under subsection (a) of this rule must end when the identified homecare worker per subsection (a) of this rule or the primary provider under the Independent Choices Program is no longer employed by the individual.

(7) An individual may employ homecare workers with a differential rate in accordance with the terms of the ratified collective bargaining agreement described in OAR 411-031-0020, if the following applies:

(a) The individual is diagnosed with quadriplegia or a condition that is substantially similar;

(b) The individual is dependent on a ventilator;

(c) The individual is eligible for and receives shift services;

(d) Within a 24-hour work period, the individual requires at least 16 hours of paid shift care and up to 8 hours of unpaid care; and

(e) The plan is approved by the Department.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

Hist.: APD 19-2015(Temp), f. & cert. ef. 9-21-15 thru 3-18-16; APD 5-2016, f. 3-15-16, cert. ef. 3-18-16; APD 12-2016(Temp), f. 6-27-16, cert. ef. 7-1-16 thru 12-27-16

411-030-0070
Maximum Hours of Service

(1) LEVELS OF ASSISTANCE FOR DETERMINING SERVICE PLAN HOURS.

(a) "Minimal Assistance" means an individual is able to perform the majority of an activity but requires some assistance from another person.

(b) "Substantial Assistance" means an individual is able to perform only a small portion of the tasks that comprise an activity without assistance from another person.

(c) "Full Assistance" means an individual needs assistance from another person through all phases of an 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 an 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 and 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 and Behaviors:
(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 is limited for each additional individual in the home.

(d) Hours authorized for ADL are paid at the rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for ADLs paid at the rates in accordance with the rate schedule. Participants of the Independent Choices Program may determine their own employee provider pay rates, but must follow all applicable wage and hour rules and regulations.

(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 an 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:
(I) Breakfast, 4 hours;
(II) Lunch, 4 hours;
(III) Supper, 8 hours.
(ii) Substantial assistance:
(I) Breakfast, 8 hours;
(II) Lunch, 8 hours;
(III) Supper, 16 hours.
(iii) Full assistance:
(I) Breakfast, 12 hours;
(II) Lunch, 12 hours;
(III) Supper, 24 hours.
(D) Shopping:
(i) Minimal assistance, 2 hours;
(ii) Substantial assistance, 4 hours;
(iii) Full assistance, 6 hours.
(E) Housecleaning:
(i) Minimal assistance, 5 hours.
(ii) Substantial assistance, 10 hours.
(iii) Full assistance, 20 hours.

(b) Hours authorized for IADL are paid at the rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for IADLs paid at the rates in accordance with the rate schedule. Participants of the Independent Choices Program may determine their own employee provider pay rates, but must follow all applicable wage and hour rules and regulations.

(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 is 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) PAYMENT FOR LIVE-IN SERVICES.

(a) Payment for live-in services is authorized only when an individual employs a live-in homecare worker or enrolls in the Independent Choices Program and meets the requirements of OAR 411-030-0068.

(b) Effective January 1, 2016, payment for live-in services is authorized only when an individual employs a live-in homecare worker or enrolls in the Independent Choices Program and meets the requirements of OAR 411-030-0068. Individuals that meet these criteria will be authorized to receive at least 16 hours per day (496 hours per month). Additional hours may be authorized by the Department to meet the needs of the individual during the hours of the homecare worker's scheduled sleep period if the homecare worker's scheduled sleep period is routinely disrupted.

(c) Rates for live-in services are paid in accordance with the rate schedule.

(d) When a live-in homecare worker is employed less than seven days per week, the total service hours must be prorated.

(5) When one or more eligible individuals in the same household is eligible for and receiving in-home services, the amount of hours authorized is subject to the following maximums:

(a) If any eligible individual in a specific household is receiving live-in services, the combined authorized hours for all eligible individuals in the same household may not exceed 19 hours within any 24-hour period or 589 hours per month.

(b) Hourly and shift service plans may not exceed 24 hours within any 24-hour period or 744 hours per month in the same household.

(6) Beginning July 1, 2016, when a homecare worker begins employment with an individual, the following limitations to the authorized hours a homecare worker may work will apply:

(a) Hourly or shift service plans of no more than 220 hours per month, not to exceed 50 hours per workweek per individual.

(b) Hourly or shift services plan of no more than 16 hours of awake care during a 24-hour work period.

(7) A provider may not receive payment from the Department for more than the total amount authorized by the Department on the service plan authorization form under any circumstances. All service payments must be prior-authorized by a case manager.

(8) 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) that may reduce the need for paid assistance.

(9) The Department may authorize paid in-home services only to the extent necessary to supplement potential or existing resources within an individual's natural supports system.

(10) Payment by the Department for Medicaid home and community-based services are only made for the tasks described in this rule as ADL, IADL tasks, and live-in services. Services must be authorized to meet the needs of an eligible individual and may not be provided to benefit an entire household.

(11) 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 OAR 411-027-0050 is met.

(c) As long as the total number of IADL task hours in the service plan does not exceed 85 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 an individual; or

(C) Extraordinary IADL needs in medication management or service-related transportation.

(d) Monthly service plans that exceed 85 hours per month in IADL tasks may be approved by the Department when an individual meets the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050.

(e) One or more individuals in the same household may exceed the maximums in section (5) of this rule in the following circumstances:

(A) The service plan authorizes payment that requires the assistance of more than one homecare worker to simultaneously perform a specific task.

(B) The service plan authorizes an additional hourly provider when the individual requires care throughout a 24 hour period and the live-in homecare worker is not able to receive five continuous hours of sleep.

(C) The ADLs of two or more individuals in the same household require a homecare worker for each individual at the same time.

(f) A homecare worker may be authorized to provide services totaling more than 176 hours per month or 40 hours per workweek if they are prior authorized by the Department. In emergency situations, when the Department is not available, a homecare worker may work critical hours, but must notify the Department within two business days.

(g) A homecare worker may be authorized by the Department to work more than 16 hours of hourly services during a 24-hour work period if an unanticipated need arises that requires the homecare worker to remain awake in order to provide the necessary care.

[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; SPD 44-2013, f. 12-13-13, cert. ef. 12-15-13; APD 11-2014, f. & cert. ef. 5-1-14; APD 19-2015(Temp), f. & cert. ef. 9-21-15 thru 3-18-16; APD 12-2016(Temp), f. 6-27-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Rate Schedule for Home and Community-Based Services
Adm. Order No.: APD 13-2016(Temp)
Filed with Sec. of State: 6-27-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 411-027-0170
Subject: The Department of Human Services (Department) is immediately amending OAR 411-027-0170 to revise the home and community based care facility rates. These rates will be consistent with the current rate table information. The new rates become effective July 1, 2016.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-027-0170
Rate Schedule for Home and Community-Based Services

(1) Rates below are in effect starting July 1, 2016.

(2) Monthly Rates:

(a) Residential Care Facilities:

(A) Base — $1405.00.

(B) Base plus 1 add-on — $1677.00.

(C) Base plus 2 add-ons — $1949.00.

(D) Base plus 3 add-ons — $2221.00.

(E) Hourly Exception Rate — $12.00 per hour.

(b) Adult Foster Homes: Rates shall be paid in accordance with the terms of collective bargaining agreements negotiated between the Service Employees International Union and the State of Oregon.

(c) Assisted Living Facilities:

(A) Level 1 — $1,128.00.

(B) Level 2 — $1,398.00.

(C) Level 3 — $1,753.00.

(D) Level 4 — $2,203.00.

(E) Level 5 — $2,650.00.

(d) Memory Care Facilities (Endorsed Units Only) — $3,686.00 per month.

(e) Contracted In-Home Care Agencies Rate — $22.32 per hour.

(f) Home Delivered Meals Rate — $9.54 per meal.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

Hist.: APD 18-2015(Temp), f. & cert. ef. 9-21-15 thru 3-18-16; ADP 3-2016, f. 3-4-16, cert. ef. 3-18-16; APD 13-2016(Temp), f. 6-27-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: ODDS: Direct Nursing Services for Adults with Intellectual or Developmental Disabilities
Adm. Order No.: APD 14-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 4-1-2016
Rules Adopted: 411-380-0010, 411-380-0020, 411-380-0030, 411-380-0040, 411-380-0050, 411-380-0060, 411-380-0070, 411-380-0080, 411-380-0090
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is adopting rules in OAR chapter 411, division 380 to make permanent temporary rules that became effective on January 1, 2016 that establish standards and procedures for the provision of direct nursing services. Direct nursing services support individuals 21 years of age or older with intellectual or developmental disabilities and complex, long-term, medical conditions that require shift staff nursing level of supports.

The rules in OAR chapter 411, division 380 define direct nursing services, specify eligibility and limitations for direct nursing services, and specify nursing service requirements for case management entities and the Department. The rules also establish and detail provider requirements including qualifications, enrollment, billing and payment, and documentation and recordkeeping requirements.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-380-0010
Statement of Purpose

(1) The rules in OAR chapter 411, division 380 establish standards and procedures for the provision of direct nursing services for adults with intellectual or developmental disabilities and complex health management support needs. These rules define eligibility for services, prescribe Medicaid provider enrollment conditions, and enact service and documentation requirements.

(2) Direct nursing services provide medical tasks to adults with intellectual or developmental disabilities and complex health management support needs in order to live as independently as possible in their home and community.

Stat. Auth.: ORS 409.050, 413.085

Stats. Implemented: ORS 409.050, 413.085

Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

411-380-0020
Definitions

(1) "Acuity Level" means the amount of the medically related support needs of an individual as measured by an assessment.

(2) "Authorization" means the approval of the case management entity for planning, provision, and payment of direct nursing services.

(3) "Case Management Entity" means the Community Developmental Disability Program or Support Services Brokerage contracted to deliver the functions of case management.

(4) "Complex Health Management Support Needs" mean those medical or nursing tasks, activities, or duties in response to a health condition or series of conditions that impacts all aspects of the care of an individual, requiring oversight by a nurse and physician.

(5) "Direct Nursing Services" mean the services described in OAR 411-380-0050 (Direct Nursing Service Requirements) that are determined medically necessary to support an individual with complex health management support needs in their home and community. Direct nursing services are provided on a shift staffing basis.

(6) "Direct Nursing Services Criteria" means the assessment to measure the acuity and support level of nursing tasks to determine eligibility for direct nursing services.

(7) "Enrolled Medicaid Provider" means an RN or LPN that meets and completes all the requirements in these rules, OAR 407-120-0300 to 0400 (Medicaid Provider Enrollment and Claiming), and OAR chapter 410, division 120 (OHA, Medicaid General Rules), as applicable.

(8) "Home Health Agency" has the meaning given that term in ORS 443.005.

(9) "Individual" means an adult applying for, or determined eligible for, Department-funded developmental disabilities services.

(10) "In-Home Care Agency" has the meaning given that term in ORS 443.305.

(11) "ISP" means "Individual Support Plan".

(12) "LPN" means a licensed practical nurse who holds a current license from the Oregon State Board of Nursing pursuant to ORS chapter 678 and OAR chapter 851, division 045 (Standards and Scope of Practice for the LPN and RN). An LPN providing direct nursing services under these rules is either an independent contractor who is an enrolled Medicaid provider or an employee of an in-home care or home health agency that is an enrolled Medicaid provider.

(13) "MMIS" means "Medicaid Management Information System". MMIS is the automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of the system include verifying provider enrollment and individual eligibility, managing health care provider claims and benefit package maintenance, and addressing a variety of Medicaid business needs.

(14) "Medicaid Provider Enrollment Agreement" means an agreement between the Department and a provider for the provision of covered services to covered individuals for payment.

(15) "National Provider Index Number" means a federally directed provider number mandated for use on Health Insurance Portability and Accountability Act (HIPAA) covered transactions by 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.

(16) "Nursing Intervention" means the actions deliberately designed, selected, and performed by a nurse to implement the Nursing Service Plan.

(17) "Nursing Service Plan" means the written guidelines developed by an RN as described in OAR 411-380-0050 (Direct Nursing Service Requirements) that identifies the specific needs of an individual and the intervention or regiment to assist the individual to achieve optimal health potential. Developing the Nursing Service Plan includes a comprehensive and focused nursing assessment of the health status of the individual as part of the standards outlined in OAR 851-045-0040(2) (Scope of Practice Standards for Registered Nurses), establishing individual and nursing goals, and determining nursing interventions to meet care objectives.

(a) The Nursing Service Plan is specific to an individual and identifies the diagnoses and health needs of the individual and all direct nursing service needs.

(b) The Nursing Service Plan is separate from the ISP as well as any service plans developed by other health professionals.

(18) "OHA" means "Oregon Health Authority".

(19) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(20) "Prior Authorization for Services" means payment authorization for direct nursing services given by the Department or contracted agencies of the Department prior to provision of the service. A physician referral is not a prior authorization for services.

(21) "Provider" means an enrolled Medicaid provider who holds a current license from the Oregon State Board of Nursing as an RN or LPN pursuant to ORS chapter 678.

(22) "RN" means a registered nurse who holds a current license from the Oregon State Board of Nursing pursuant to ORS chapter 678 and OAR chapter 851, division 045 (Standards and Scope of Practice for the LPN and RN). An RN providing direct nursing services under these rules is either an independent contractor who is an enrolled Medicaid provider or an employee of an in-home care or home health agency that is an enrolled Medicaid provider.

(23) "These Rules" mean the rules in OAR chapter 411, division 380.

(24) "Third Party Resources" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an individual.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085
Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

411-380-0030
Eligibility and Limitations for Direct Nursing Services

(1) ELIGIBILITY. To be eligible for direct nursing services, an individual must:

(a) Be 21 years of age or older;

(b) Be determined eligible for developmental disabilities services by a Community Developmental Disabilities Program in the county of origin as described in OAR 411-320-0080;

(c) Be OSIPM eligible;

(d) Meet the level of care as defined in OAR 411-320-0020;

(e) Based on a functional needs assessment, require oversight for complex health management support needs;

(f) Based on a Direct Nursing Services Criteria completed by the Department, score 45 or higher; and

(g) Have health impairments requiring long term direct nursing services determined medically necessary and appropriate based on the order of a physician.

(2) ACUITY LEVELS. The amount of hours available for direct nursing services is based on the following acuity levels as measured by the Direct Nursing Services Criteria:

(a) Level 1: Score of 75 or above and on a ventilator for 20 hours or more per day = up to a maximum of 554 hours per month for direct nursing services.

(b) Level 2: Score of 70 or above = up to a maximum of 462 hours per month for direct nursing services.

(c) Level 3: Score of 65 to 69 = up to a maximum of 385 hours per month for direct nursing services.

(d) Level 4: Score of 60 to 64 = up to a maximum of 339 hours per month for direct nursing services.

(e) Level 5: Score of 50 to 59 or if an individual requires ventilation for sleeping hours = up to a maximum of 293 hours per month for direct nursing services.

(f) Level 6: Score of 45 to 49 = up to a maximum of 140 hours per month for direct nursing services.

(3) SERVICE DELIVERY.

(a) Except as limited under section (4)(a) of this rule, direct nursing services may be delivered in the home of an individual, in an adult foster home, at an employment or day service site, or in the community.

(b) The hours for direct nursing services for individuals accessing other attendant care services at an employment setting or in the community, are prorated based on the acuity level of the individual between the employment setting and the home or adult foster home of the individual.

(4) LIMITATIONS.

(a) Direct nursing services are excluded for:

(A) An individual residing in a licensed 24-hour residential setting as described in OAR chapter 411, division 325;

(B) An individual while in a medical or psychiatric hospital; or

(C) An individual residing in a school, nursing facility, assisted living facility, or residential care facility.

(b) Direct nursing services may not substitute for or duplicate other direct or private duty nursing services provided by State Plan or third party resources.

(c) Direct nursing services provided concurrently with care being provided under OAR 410-142-0240 (OHA, Hospice Services) or OAR 410-127-0040 (OHA, Home Health Care Services) are not reimbursable under these rules.

(d) Direct nursing services are not covered in conjunction with any intravenous, enteral, or parenteral related skilled nursing services as described in OAR 410-148-0300 (OHA, Home Enteral/Parenteral Nutrition and IV Services).

(e) Direct nursing services may not duplicate school-based nursing services covered under the provision of the Individuals with Disabilities Education Act (IDEA).

(f) Direct nursing services do not include:

(A) Hours spent receiving professional training or career development;

(B) Administrative functions such as non-individual-specific services, quality assurance reviews, authoring health related agency policies and procedures, or providing general training for caregivers;

(C) Travel time spent in transit to or from the residence of the provider; or

(D) Nursing services as defined under OAR chapter 411, division 048 (Long Term Care Community Nursing). This includes nurse delegation.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085
Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

411-380-0040
Complaints, Notifications of Planned Actions and Hearings

(1) INDIVIDUAL COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015 (Complaints).

(b) The case management entity must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015 (Complaints).

(c) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(2) NOTIFICATION OF PLANNED ACTION. In the event that direct nursing services are denied, reduced, suspended, or terminated or voluntarily reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020 (Notification of Planned Action).

(3) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025 (Contested Case Hearings for Reductions, Suspensions, Terminations, or Denials).

(b) An individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025 (Contested Case Hearings for Reductions, Suspensions, Terminations, or Denials) for a denial, reduction, suspension, or termination of direct nursing services.

(c) Upon entry, individual request, and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085
Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

411-380-0050
Direct Nursing Service Requirements

(1) DIRECT NURSING SERVICES CRITERIA. The Department completes an assessment using the Direct Nursing Services Criteria at the following times:

(a) For initial eligibility of direct nursing services;

(b) As part of annual ISP planning, but no longer than 12 months from the last assessment; and

(c) After any significant change of condition, such as hospitalization, emergency visits, or significant changes in the health status of the individual, reported by the case management entity or provider.

(2) NURSING SERVICE PLAN. Each individual must have a written Nursing Service Plan that meets the standards in OAR chapter 851, division 045 (Standards and Scope of Practice for the LPN and RN).

(a) An RN must develop a Nursing Service Plan within seven days of the initiation of direct nursing services and submit the Nursing Service Plan to the case management entity and Department for review.

(b) The RN must review, update, and resubmit the Nursing Service Plan to the case management entity and the Department in the following instances:

(A) Every six months;

(B) Within seven working days of a change of RN;

(C) With any request for authorization of an increase in hours of service; or

(D) After any significant change of condition, such as hospitalization, emergency visits, or significant change in the health status of the individual.

(c) The RN must share the Nursing Service Plan with the individual and if applicable, the legal representative, designated representative, foster care provider, or agency providers.

(3) Direct nursing services must be documented as part of the ISP. The maximum number of eligible hours based on the Direct Nursing Services Criteria must be authorized in the ISP.

(4) Direct nursing services may not duplicate or occur at the same time as attendant care services, except when the delivery of attendant care is provided by a personal support worker or provider agency as defined in OAR 411-317-0000, and the individual;

(a) Has been assessed needing Department approved 2:1 attendant care supports based on the results of a functional needs assessment;

(b) Is attending employment or day service activities; or

(c) Needs 2:1 staffing in the community.

(5) Direct nursing services include, but are not limited to:

(a) Continuous assessment and reassessment of the medical condition of the individual, as part of each shift;

(b) Skilled nursing tasks;

(c) Nursing interventions;

(d) Implementation of treatment and therapies;

(e) Data collection;

(f) Documentation;

(g) Written and oral communication with individuals, physicians and other health professionals, other caregivers, case management entities, ISP teams, foster care providers, and agency providers; and

(h) Other nursing responsibilities under OAR 851-045-0040 (Oregon State Board of Nursing Scope of Practice Standards for All Licensed Nurses) approved by the Department.

(6) Direct nursing services must be provided on a shift staffing basis. Shifts are from a minimum of four hours to a maximum of 16 hours.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085
Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

411-380-0060
Qualifications for Providers of Direct Nursing Services

(1) The direct nursing services provided under these rules may be delivered by the following enrolled Medicaid providers:

(a) Self-employed LPNs or RNS licensed under ORS 678.021;

(b) Home health agencies licensed under ORS 443.015 and meeting the requirements in OAR chapter 333, division 027 (Home Health Agencies);

(c) In-home care agencies licensed under ORS 443.315 and meeting the requirements in OAR chapter 333, division 536 (In-Home Care Agencies);

(d) An adult foster home provider as described in OAR 411-360-0140 (Standards and Practices for Health Care) and section (2) of this rule; and

(e) A family member as described in section (2) of this rule.

(2) The decision to have an adult foster home provider or family member deliver direct nursing services must be made by the individual and the ISP team and may not be for the convenience of the adult foster home provider or family member.

(3) The legal representative of an individual is prohibited from providing direct nursing services.

(4) A provider of direct nursing services must;

(a) Be a licensed RN or LPN with a current and unencumbered license; and

(b) Meet and maintain provider enrollment requirements under OAR 407-120-0320 (Provider Enrollment) as follows:

(A) Providers delivering services prior to January 1, 2016 must meet the provider enrollment requirements under OAR 407-120-0320 (Provider Enrollment) no later than June 28, 2016.

(B) Provider applicants enrolling on or after January 1, 2016 must meet the provider enrollment requirements under OAR 407-120-0320 (Provider Enrollment) upon enrollment.

(5) Providers must submit a resume to the case management entity indicating the education, skills, and abilities necessary to provide nursing services in accordance with Oregon law. At least one year of experience working with individuals with intellectual or developmental disabilities is recommended, but not required.

(6) The provider must maintain in force, at the expense of the provider, professional liability insurance with a combined single limit of not less than $1,000,000 for each claim, incident, or occurrence. Professional liability insurance is to cover damages caused by error, omission, or negligent acts related to the professional services.

(a) The provider must provide written evidence of insurance coverage to the Department prior to beginning work and at any time upon the request of the Department.

(b) There must be no cancellation of insurance coverage without 30 days prior written notice to the Department.

(7) PROVIDER ENROLLMENT.

(a) Providers must enroll through the MMIS system by:

(A) Completing and submitting the Medicaid Provider Enrollment Application that includes the Provider Enrollment Agreement;

(B) Completing a Criminal Background Check as described in OAR 407-007-0200 to 0370 (Criminal History Checks); and

(C) Enrolling, receiving, and submitting a National Provider Index Number.

(b) An applicant listed in the exclusions database of the Office of the Inspector General is not eligible to become an enrolled Medicaid provider per OAR 410-120-1400(3)(b) (OHA, Provider Sanctions).

(8) All enrolled Medicaid providers must comply with federal, state, and Department conflict of interest regulations or policy.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085
Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

411-380-0070
Provider Disenrollment and Termination

(1) Enrolled Medicaid providers may be denied enrollment, terminated, or prohibited from providing direct nursing services for any of the following:

(a) Violation of any part of these rules;

(b) A substantiation of a violation of the protective service and abuse rules in OAR chapter 411, division 020 (Adult Protective Services - General) or OAR chapter 407, division 045 (Office of Investigations and Training);

(c) Any sanction or action as a result of an investigation of the Oregon State Board of Nursing;

(d) Failure to keep required licensure or certifications current;

(e) Failure to provide copies of the records described in these rules to OHA, the Department, or case management entity;

(f) Failure to participate in the review of the Nursing Service Plan or care coordination meetings when requested by the case management entity;

(g) Failure to provide services;

(h) Fraud or misrepresentation in the provision of direct nursing services;

(i) Evidence of conduct derogatory to the standards of nursing as described in OAR 851-045-0070 (Conduct Derogatory to the Standards of Nursing Defined) that results in referral to the Oregon State Board of Nursing;

(j) A demonstrated pattern of repeated unsubstantiated complaints of neglect or abuse per OAR chapter 411, division 020 (Adult Protective Services - General) or OAR chapter 407, division 045 (Office of Investigations and Training); or

(k) The provider is listed in the exclusions database of the Office of the Inspector General.

(2) Enrolled Medicaid providers may appeal a termination of their Medicaid provider number based on OAR 407-120-0360(8)(g) (Consequences of Non-Compliance and Provider Sanctions) and OAR chapter 410, division 120 (OHA, Medical Assistance Programs), as applicable.

(3) An enrolled Medicaid provider of direct nursing services must provide advance written notice to the Department and any individuals the provider is delivering direct nursing services to at least 30 days prior to no longer providing direct nursing services.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085
Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

411-380-0080
Provider Documentation and Records

(1) Documentation of direct nursing services must be written in an accurate, timely, thorough, and clear manner.

(2) Documentation must comply with OAR chapter 851 (Oregon State Board of Nursing) and must include:

(a) The name of the individual on each page of documentation;

(b) The date of service;

(c) Time of start and end of service delivery by each provider;

(d) Anything unusual from the standard plan of care expanded in the narrative;

(e) Interventions;

(f) Outcomes, including the response of the individual to services delivered;

(g) Nursing assessment of the status of the individual and any changes in that status per each working shift; and

(h) Full signature of the provider.

(3) Documentation of provided direct nursing services must be sent to the case management entity upon request or as outlined in the ISP and maintained in the home, foster home, or the place of business of the provider of services.

(4) Providers must furnish requested documentation immediately upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, OHA, Centers for Medicare and Medicaid Services, or their authorized representatives, or within the timeframe specified in the written request. Failure to comply with the request may be considered by the Department as reason to deny or recover payments.

(5) Access to records by the Department including, but not limited to, medical, nursing, behavior, psychiatric, or financial records, to include providers and vendors providing goods and services, does not require authorization or release by the individual or the legal representative of the individual.

(6) Per OAR 410-120-1360(2)(e) (OHA, Requirements for Financial, Clinical and Other Records), providers must;

(a) Retain billing forms, timesheets, and financial records for at least five years from the date of service; and

(b) Retain clinical record documentation of provided services for at least seven years from the date of service.

Stat. Auth.: ORS 409.050, 413.085
Stats. Implemented: ORS 409.050, 413.085
Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

411-380-0090
Provider Billing and Payment

(1) AUTHORIZATION OF HOURS. Authorization for direct nursing service hours are:

(a) Based on acuity levels from the Direct Nursing Services Criteria; and

(b) Authorized in the ISP by the case management entity.

(2) PRIOR AUTHORIZATION.

(a) Providers must request electronic authorization for direct nursing service hours through MMIS and have hours prior authorized by the Department.

(b) The Department may withdraw, modify, or deny prior authorizations in the event of any of the following:

(A) Change in the status of the individual, such as eligibility for direct nursing services, hospitalization, improvement in health status, or death;

(B) Decision of the individual, family, or legal representative, to change providers;

(C) Failure to comply with the delivery of direct nursing services and documentation; or

(D) Failure to perform other expected duties.

(3) CLAIMS.

(a) A provider must comply with the rules for authorization of claims as written in OAR 410-120-1300 (OHA, Timely Submission of Claims) and OAR 410-120-1320 (OHA, Authorization of Payment).

(b) A provider must follow all Department required documentation procedures for timesheets, invoices, and signatures and submit true and accurate information.

(c) Medicaid funds are the payer of last resort. A provider must bill all third party resources until all resources are exhausted.

(d) A provider may not submit the following to the Department or case management entity:

(A) A false billing form for payment;

(B) A billing form for payment that has been, or is expected to be, paid by another source; or

(C) Any billing form for services that have not been provided.

(e) The billing form used to submit a claim must include the prior authorization number.

(f) A provider must sign the billing form acknowledging agreement with the terms and conditions of the claim and attesting that the hours were delivered as billed.

(g) Timely submission of claims is required per OAR 410-120-1300(1) (OHA, Timely Submission of Claims). A provider must submit a claim for payment to the case management entity within 12 months of the date of service.

(h) The case management entity must review the claim and match the number of hours claimed by the provider against the number of hours prior authorized. The case management entity must review, approve, and forward the claim to the Department in a timely manner.

(4) PAYMENT.

(a) Payment for direct nursing services is made in accordance with;

(A) These rules;

(B) OAR 410-120-1300 (OHA, Timely Submission of Claims);

(C) OAR 411-120-1320 (OHA, Authorization of Payment);

(D) OAR 411-120-1340 (OHA, Payment);

(E) OAR 411-120-1380 (OHA, Compliance with Federal and State Statutes);

(F) OAR 407-120-300 to 400 (Provider Enrollment and Claiming); and

(G) OAR 407-120-1505 (Provider and Contractor Audits, Appeals, and Post Payment Recoveries).

(b) 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 (Convictions under ORS 443.004 Resulting in Ineligibility for Aging and People with Disabilities Program and Developmental Disabilities Program).

(c) Payment for direct nursing services are fee for service with payment made subsequent to the delivery of the services.

(d) The Department does not pay for services that are not authorized in the ISP.

(e) Providers must be present with an individual in the delivery of direct nursing services in order to claim payments.

(f) Holidays are paid at the same rate as non-holidays.

(g) Hours will not be authorized for overtime.

(h) Payment by the Department for direct nursing services is considered payment in full for the services rendered under Medicaid. A provider may not demand or receive additional payment for direct nursing services from an individual, family member, foster care provider, agency provider, or any other source, under any circumstances.

(i) Payment may be denied based on the provisions of OAR 410-120-1320 (OHA, Authorization of Payment) and the provisions of these rules.

(5) OVERPAYMENT. An overpayment occurs when a provider submits a claim or encounter, or received payment to which the provider is not properly entitled. The determination of overpayment is based on OAR 410-120-1397(5)(a)-(h) (OHA, Recovery of Overpayments to Providers - Recoupment). The Department and OHA recoup all overpayments under OAR 410-120-1397 (OHA, Recovery of Overpayments to Providers - Recoupment).

Stat. Auth.: ORS 409.050, 413.085

Stats. Implemented: ORS 409.050, 413.085

Hist.: APD 28-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 14-2016, f. 6-28-16, cert. ef. 6-29-16

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Rule Caption: ODDS: Support Service Brokerages for Adults with Intellectual or Developmental Disabilities

Adm. Order No.: APD 15-2016

Filed with Sec. of State: 6-28-2016

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Notice Publication Date: 5-1-2016

Rules Amended: 411-340-0010, 411-340-0020, 411-340-0030, 411-340-0040, 411-340-0050, 411-340-0060, 411-340-0070, 411-340-0080, 411-340-0090, 411-340-0100, 411-340-0110, 411-340-0120, 411-340-0150

Rules Repealed: 411-340-0125, 411-340-0130, 411-340-0135, 411-340-0140, 411-340-0160, 411-340-0170, 411-340-0180

Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the rules for Support Service Brokerages (Brokerages) in OAR chapter 411, division 340 to make permanent the following temporary changes that became effective on January 1, 2016:

- To provide consistency and streamline definitions across services, the Department removed general definitions included in OAR 411-317-0000; and

- The Department shortened the certification period of a Brokerage from five years to two years.

In addition, the Department is proposing to restructure the rules in OAR chapter 411, division 340 to ensure uniform standards for case management, provide more consistency, consolidate requirements, and remove redundancies. Specifically, the Department is proposing to —

- Relocate qualifications and related requirements for case management services to OAR chapter 411, division 415;

- Repeal OAR 411-340-0125 (Crisis Supports in Support Services) to align rules with current Department practice;

- Relocate eligibility requirements, provider qualifications, and service descriptions for the services that a personal agent may authorize. The portions related to attendant care, skills training, and relief care are being moved to new rules for community living supports in OAR chapter 411, division 450 and the remaining services available under the 1915(k) and 1915(c) funding authorities are being moved to new rules for ancillary services in OAR chapter 411, division 435;

- Move the language in OAR 411-340-0170 that is used to certify provider organizations to the new rules for in-home services in OAR chapter 411, division 450. Provider organizations will be required to become certified under OAR chapter 411, division 323 and endorsed to OAR chapter 411, division 450; and

- Move the language in OAR 411-340-0135 and 411-340-0160 that describes the requirements for independent providers and employers of independent providers to OAR chapter 411, division 375.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-340-0010
Statement of Purpose

(1) The rules in OAR chapter 411, division 340 prescribe standards, responsibilities, and procedures for Support Service Brokerages. Support Service Brokerages assist adults with intellectual or developmental disabilities to identify and address support needs so that an adult with an intellectual or developmental disability may live in his or her own home or in the family home.

(2) Support Service Brokerages certified under these rules are expected to identify, strengthen, expand, and where required, supplement private, public, formal, and informal support available to adults with intellectual or developmental disabilities so that an adult with an intellectual or developmental disability may exercise self-determination in the design and direction of his or her life.

Stat. Auth.: ORS 409.050, 427.402, & 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695

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 309-041-1750, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 8-2005, f. & cert. ef. 6-23-05; SPD 8-2008, f. 6-27-08, cert. ef. 6-29-08; SPD 8-2009, f. & cert. ef. 7-1-09; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0020
Definitions and Acronyms

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 340:

(1) "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 brokerage and support services for individuals with intellectual or developmental disabilities.

(2) "Brokerage Director" means the Director of a publicly or privately-operated Brokerage, who is responsible for administration and provision of services according to these rules, or the designee of the Brokerage Director.

(3) "CDDP" means "Community Developmental Disabilities Program".

(4) "Certificate" means the document issued by the Department to a Brokerage that certifies the Brokerage is eligible to receive state funds for the provision of services under these rules.

(5) "Geographic Service Area" means the area within the state of Oregon where a case management entity is approved to provide developmental disabilities services.

(6) "Policy Oversight Group" means the group that meets the requirements of OAR 411-340-0150 that is formed to provide individual-based leadership and advice to each Brokerage regarding issues, such as development of policy, evaluation of services, and use of resources.

(7) "Support Services" mean the case management services provided by a personal agent employed by a Brokerage and the services authorized by the Brokerage.

(8) "These Rules" mean the rules in OAR chapter 411, division 340.

Stat. Auth.: ORS 409.050, 427.402 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695

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; SPD 31-2013, f. 7-22-13, cert. ef. 8-1-13; SPD 32-2013(Temp), f. 7-22-13, cert. ef. 8-1-13 thru 12-28-13; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 26-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 44-2014, f. 12-26-14, cert. ef. 12-28-14; APD 32-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0030
Certification of Support Service Brokerages

(1) CERTIFICATE REQUIRED.

(a) No person or governmental unit acting individually or jointly with any other person or governmental unit may establish, conduct, maintain, manage, or operate a Brokerage without being certified by the Department under this rule.

(b) Certificates are not transferable or assignable and are issued only for the Brokerage and people or governmental units named in the application.

(c) Certificates issued on or after January 1, 2016 are effective for a maximum of two years.

(d) The Department shall conduct a review of the Brokerage prior to the issuance of a certificate.

(2) CERTIFICATION. A Brokerage must apply for an initial certificate and for a certificate renewal.

(a) The application must be on a form provided by the Department and must include all information requested by the Department.

(b) The applicant requesting certification as a Brokerage must identify the maximum number of individuals to be served and the geographic service area.

(c) To renew certification, the Brokerage must make application at least 30 days, but not more than 120 days, prior to the expiration date of the existing certificate. On renewal of certification, no increase in the maximum number of individuals to be served by the Brokerage may be certified unless specifically approved by the Department.

(d) Application for renewal must be filed no more than 120 days prior to the expiration date of the existing certificate and extends the effective date of the existing certificate until the Department takes action upon the application for renewal.

(e) Failure to disclose requested information on the application or providing incomplete or incorrect information on the application may result in denial, revocation, or refusal to renew the certificate.

(f) Prior to issuance or renewal of the certificate, the applicant must demonstrate to the satisfaction of the Department that the applicant is capable of providing services identified in a manner consistent with the requirements of these rules.

(3) CERTIFICATION EXPIRATION, TERMINATION OF OPERATIONS, OR CERTIFICATE RETURN.

(a) Unless revoked, suspended, or terminated earlier, each certificate to operate a Brokerage expires on the expiration date specified on the certificate.

(b) If a certified Brokerage is discontinued, the certificate automatically terminates on the date operation is discontinued.

(4) CHANGE OF OWNERSHIP, LEGAL ENTITY, LEGAL STATUS, OR MANAGEMENT CORPORATION. The Brokerage must notify the Department in writing of any pending action resulting in a five percent or more change in ownership and of any pending change in the legal entity, legal status, or management corporation of the Brokerage.

(5) NEW CERTIFICATE REQUIRED. A new certificate for a Brokerage is required upon change in the ownership, legal entity, or legal status of a Brokerage. The Brokerage must submit a certificate application at least 30 days prior to change in ownership, legal entity, or legal status.

(6) CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may deny, revoke, or refuse to renew a certificate when the Department finds the Brokerage, the Brokerage Director, or any person holding five percent or greater financial interest in the Brokerage:

(a) Demonstrates substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized and the Brokerage fails to correct the noncompliance within 30 calendar days of receipt of written notice of non-compliance;

(b) Has demonstrated, during two inspections within a six year period, a substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized. For the purpose of this rule, "inspection" means an on-site review of the service site by the Department for the purpose of investigation or certification;

(c) Has been convicted of a felony or any crime as described in OAR 407-007-0275;

(d) Has been convicted of a misdemeanor associated with the operation of a Brokerage;

(e) Falsifies information required by the Department to be maintained or submitted regarding services of individuals, program finances, or individuals' funds;

(f) Has been found to have permitted, aided, or abetted any illegal act that has had significant adverse impact on individual health, safety, or welfare; or

(g) Has been placed on the list of excluded or debarred providers by the Office of Inspector General (http://exclusions.oig.hhs.gov/).

(7) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. Following a Department finding that there is a substantial failure to comply with these rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in section (6) of this rule has occurred, the Department may issue a notice of certificate revocation, denial, or refusal to renew.

(8) IMMEDIATE SUSPENSION OF CERTIFICATE. When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the certificate holder, immediately suspend a certificate without a pre-suspension hearing and the Brokerage may not continue operation.

(9) HEARING. An applicant for a certificate or a certificate holder may request a hearing pursuant to the contested case provisions of ORS chapter 183 upon written notice from the Department of denial, suspension, revocation, or refusal to renew a certificate. In addition to, or in lieu of a hearing, the applicant or certificate holder may request an administrative review by the Director of the Department. An administrative review does not preclude the right of the applicant or certificate holder to a hearing.

(a) The applicant or certificate holder must request a hearing within 60 days of receipt of written notice by the Department of denial, suspension, revocation, or refusal to renew a certificate. The request for a hearing must include an admission or denial of each factual matter alleged by the Department and must affirmatively allege a short plain statement of each relevant, affirmative defense the applicant or certificate holder may have.

(b) In the event of a suspension pursuant to section (8) of this rule and during the first 30 days after the suspension of a certificate, the Brokerage may submit a written request to the Department for an administrative review. The Department shall conduct the review within 10 days after receipt of the request for an administrative review. Any review requested after the end of the 30-day period following certificate suspension is treated as a request for a hearing under subsection (a) of this section. If following the administrative review the suspension is upheld, the Brokerage may request a hearing pursuant to the contested case provisions of ORS chapter 183.

Stat. Auth.: ORS 409.050, 427.402, 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400-410, 430.610, 430.620, 430.662-695

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 309-041-1770, 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 25-2009(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 25-2010(Temp), f. & cert. ef. 11-17-10 thru 5-16-11; SPD 10-2011, f. & cert. ef. 5-5-11; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 32-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0040
Abuse and Unusual Incidents

(1) ABUSE PROHIBITED. No individual as defined in OAR 411-340-0020 shall be abused nor shall any employee, staff, or volunteer of a Brokerage condone abuse.

(a) Brokerages must have in place appropriate and adequate disciplinary policies and procedures to address instances when a staff member has been identified as an accused person in an abuse investigation as well as when the allegation of abuse has been substantiated.

(b) All employees of a Brokerage are mandatory reporters. The Brokerage must:

(A) Notify all employees of mandatory reporting status at least annually on forms provided by the Department; and

(B) Provide all employees with a Department-produced card regarding abuse reporting status and abuse reporting.

(2) INCIDENT REPORTS.

(a) A Brokerage must prepare an incident report for instances of potential or suspected abuse or an unusual incident, involving an individual and a Brokerage employee. The incident report must be placed in the record of the individual and must include:

(A) Conditions prior to or leading to the potential or suspected abuse or unusual incident;

(B) A description of the potential or suspected abuse or unusual incident;

(C) Staff response at the time; and

(D) Review by the Brokerage administration and follow-up to be taken to prevent recurrence of the potential or suspected abuse or unusual incident.

(b) A Brokerage must send copies of all incident reports involving potential or suspected abuse that occurs while an individual is receiving brokerage or support services to the CDDP.

(3) IMMEDIATE NOTIFICATION

(a) The brokerage must immediately report to the CDDP, any incident or allegation of potential or suspected abuse falling within the scope of OAR 407-045-0260.

(A) When an abuse investigation has been initiated, the CDDP provides notice according to OAR 407-045-0290.

(B) When an abuse investigation has been completed, the CDDP provides notice of the outcome of the investigation according to OAR 407-045-0320.

(b) In the case of emergency overnight hospitalization due to illness or injury to an individual, the Brokerage must immediately notify the legal representative, parent, next of kin, designated contact person, or other significant person of the individual (as applicable).

(c) In the event of the death of an individual, the Brokerage must immediately notify:

(A) The Office of Developmental Disabilities Services;

(B) The legal representative, parent, next of kin, designated contact person, or other significant person of the individual (as applicable); and

(C) The CDDP.

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695
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 309-041-1780, 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 25-2009(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 25-2010(Temp), f. & cert. ef. 11-17-10 thru 5-16-11; SPD 10-2011, f. & cert. ef. 5-5-11; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0050
Inspections and Investigations

(1) Brokerages certified under these rules must allow the following types of investigations and inspections:

(a) Quality assurance and on-site inspections;

(b) Complaint investigations; and

(c) Abuse investigations.

(2) The Department, CDDP, Oregon Health Authority, or other appropriate authority performs all inspections and investigations.

(a) Any inspection or investigation may be unannounced.

(b) The Department may review the implementation of these rules as needed to ensure compliance. Following a Department review, the Department issues a report to the Brokerage identifying areas of compliance and areas in need of improvement.

(c) The Department or the CDDP conducts abuse investigations as set forth in OAR 407-045-0250 to OAR 407-045-0360 and completes abuse investigation and protective services reports according to OAR 407-045-0320. Upon completion of the abuse investigation and protective services report and in accordance with OAR 407-045-0330, the Department or CDDP provides the sections of the report that are public records and not exempt from disclosure under the public records law.

(3) All documentation and written reports required by this rule and other relevant administrative rules must be:

(a) Open to inspection and investigation by the Department, CDDP, Oregon Health Authority, or other appropriate authority; and

(b) Submitted within the time allotted.

(4) If, following a Department review, the Brokerage is not in substantial compliance with these rules, the Brokerage must respond to a plan of improvement within 45 days of the review report being issued, or in a time specified by the Department. The Department may conduct additional reviews as necessary to ensure improvement measures have been achieved. The Department may offer, or the Brokerage may request, technical assistance or training.

(5) ABUSE INVESTIGATIONS.

(a) When abuse is alleged or death of an individual has occurred and a law enforcement agency, the Department, or CDDP has determined to initiate an investigation, the Brokerage may not conduct an internal investigation without prior authorization from the Department. For the purposes of this rule, an "internal investigation" is defined as:

(A) Conducting interviews with the alleged victim, witness, the accused person, or any other person who may have knowledge of the facts of the abuse allegation or related circumstances;

(B) Reviewing evidence relevant to the abuse allegation, other than the initial report; or

(C) Any other actions beyond the initial actions of determining:

(i) If there is reasonable cause to believe that abuse has occurred;

(ii) If the alleged victim is in danger or in need of immediate protective services;

(iii) If there is reason to believe that a crime has been committed; or

(iv) What, if any, immediate personnel actions must be taken.

(b) Upon completion of the abuse investigation by the Department, CDDP, or a law enforcement agency, a Brokerage may conduct an investigation without further Department approval to determine if any other personnel actions are necessary.

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695
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 309-041-1790, 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 25-2009(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 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 44-2014, f. 12-26-14, cert. ef. 12-28-14; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0060
Complaints, Notification of Planned Action, and Hearings

(1) COMPLAINTS.

(a) Complaints must be addressed in accordance with OAR 411-318-0015.

(b) The Brokerages must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015.

(c) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual.

(2) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disabilities service is denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(3) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(b) An individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025.

(c) Upon entry and request and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695
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 309-041-1800, 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 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 25-2010(Temp), f. & cert. ef. 11-17-10 thru 5-16-11; (Temp) Repealed by SPD 10, 2011, f. & cert. ef. 5-5-11; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 26-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 44-2014, f. 12-26-14, cert. ef. 12-28-14; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0070
Personnel Policies and Practices

(1) Brokerages must maintain up-to-date written position descriptions for all staff as well as a file, available to the Department, the Oregon Health Authority, or other appropriate authority for inspection that includes written documentation of the following for each staff:

(a) Reference checks and confirmation of qualifications prior to hire;

(b) Written documentation of an approved background check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370;

(c) Satisfactory completion of basic orientation, including instructions for mandatory reporting and training specific to intellectual or developmental disabilities and skills required to carry out assigned work if the employee is to provide direct assistance to individuals;

(d) Written documentation of employee notification of mandatory reporter status;

(e) Written documentation of any founded report of child abuse or substantiated abuse;

(f) Written documentation of any complaints filed against the staff and the results of the complaint process, including any disciplinary action; and

(g) Legal eligibility to work in the United States.

(2) Any employee providing direct assistance to individuals must be at least 18 years of age and capable of performing the duties of the job as described in a current job description signed and dated by the employee.

(3) An application for employment at the Brokerage must inquire whether an applicant has had any founded reports of child abuse or substantiated abuse.

(4) Any employee of the Brokerage, or any subject individual defined by OAR 407-007-0210, who has or will have contact with an eligible individual of support services, must have an approved background check in accordance with OAR 407-007-0200 to 407-007-0370 and under ORS 181.534.

(5) A person may not be authorized as a provider or meet qualifications as described in this rule if the person has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(6) Section (5) of this rule does not apply to employees of the brokerage who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(7) Each Brokerage regulated by these rules must be a drug-free workplace.

(8) BROKERAGE DIRECTOR.

(a) The Brokerage must employ a full-time Brokerage Director who is responsible for the daily operations of the Brokerage in compliance with these rules and who has authority to make budget, staffing, policy, and procedural decisions for the Brokerage.

(b) In addition to the general staff qualifications in sections (1) and (2) of this rule, the Brokerage Director must have:

(A) A minimum of a bachelor's degree and two years of experience, including supervision, in the field of 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.

(9) PERSONAL AGENTS.

(a) Each personal agent must meet the qualifications of a case manager as described in OAR 411-415-0040.

(b) A Brokerage must submit a written variance request to the Department prior to employing 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.

(i) The proposal must specify activities, timelines, and responsibility for costs incurred in completing the alternative plan.

(ii) 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.

(c) The duties of the personal agent must be specified in a job description and include, at a minimum:

(A) The delivery of case management services to individuals as described in OAR chapter 411, division 415; and

(B) Assisting the Brokerage Director in the identification of existing and insufficient service delivery resources or options.

(10) Qualified staff of the Brokerage 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 Brokerage staff, depending on available resources.

(11) Staff must appear as a witness on behalf of the Department during an informal conference and hearing when required by the Department. Staff may not act as a representative for the claimant during an informal conference and hearing.

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695
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 309-041-1810, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; 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 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 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0080
Record Requirements

(1) INDIVIDUAL RECORD REQUIREMENTS. The Brokerage must maintain current, up-to-date records for each individual receiving brokerage and support services and must make these records available to the Department upon request. The individual or the legal representative of the individual may access any portion of the record upon request. Individual records must include, at minimum:

(a) Application and eligibility information received from the referring CDDP; and

(b) Documents related to determining eligibility for brokerage and support services;

(2) CONFIDENTIALITY AND DISCLOSURE.

(a) Individual records must be kept confidential in accordance with ORS 179.505 and any Department rules or policies pertaining to individual records.

(b) For the purpose of disclosure from individual medical records under these rules, Brokerages are considered "providers" as defined in ORS 179.505(1) and ORS 179.505 is applicable.

(c) Access to records by the Department does not require authorization by an individual or the legal or designated representative or family of the individual.

(d) For the purpose of disclosure of non-medical individual records, all or portions of the information contained in the non-medical individual records may be exempt from public inspection under the personal privacy information exemption to the public records law set forth in ORS 192.502(2).

(3) GENERAL FINANCIAL POLICIES AND PRACTICES. The Brokerage must:

(a) Maintain up-to-date accounting records consistent with generally accepted accounting principles that accurately reflect all revenue by source, all expenses by object of expense, and all assets, liabilities, and equities;

(b) As a Brokerage offering services to the general public, establish and revise, as needed, a fee schedule identifying the cost of each service provided. Billings for Medicaid funds may not exceed the customary charges to private individuals for any like item or services charged by the Brokerage; and

(c) Develop and implement written statements of policy and procedure as are necessary and useful to assure compliance with any Department rule pertaining to fraud and embezzlement.

(4) 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 at least three years after the close of the contract period.

(b) Individual records must be kept for at least seven years.

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695
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 309-041-1820, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 8-2005, f. & cert. ef. 6-23-05; 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 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 44-2014, f. 12-26-14, cert. ef. 12-28-14; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0090
Request for Variance

(1) A variance that does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws may be granted to a Brokerage:

(a) If the Brokerage lacks the resources needed to implement the standards required in these rules;

(b) If implementation of the proposed alternative services, methods, concepts, or procedures shall result in services or systems that meet or exceed the standards in these rules; or

(c) If there are other extenuating circumstances.

(2) The Brokerage requesting a variance must submit a written application to the Department that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) A description of the alternative practice, service, method, concept, or procedure proposed, including how the health and safety of individuals receiving services shall be protected to the extent required by these rules;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) If the variance applies to the services to an individual, evidence that the variance is consistent with the currently authorized ISP for the individual.

(3) The request for a variance is approved or denied by the Department. The decision of the Department is sent to the Brokerage and to all relevant Department programs or offices within 45 days from the receipt of the variance request.

(4) The Brokerage may request an administrator review of the denial of a variance request by sending a written request for review to the Director of the Department. The decision of the Director is the final response from the Department.

(5) The Department determines the duration of the variance.

(6) The Brokerage may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695
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 309-041-1830, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 8-2005, f. & cert. ef. 6-23-05; SPD 8-2008, f. 6-27-08, cert. ef. 6-29-08; SPD 8-2009, f. & cert. ef. 7-1-09; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 44-2014, f. 12-26-14, cert. ef. 12-28-14; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0100
Eligibility for Brokerage and Support Services

(1) Individuals determined eligible for brokerage and support services may not be denied 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. In order to be eligible for brokerage and support services, an individual must:

(a) Be an adult;

(b) Be an Oregon resident who meets the citizenship and alien status requirements of OAR 461-120-0110;

(c) Be determined eligible for developmental disabilities services by the CDDP of the county of origin as described in OAR 411-320-0080; and

(d) Reside in their own or family home.

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.40–427.410, 430.610, 430.620 & 430.662–430.695; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0110
Standards for Entry and Exit

(1) ENTRY.

(a) To enter a Brokerage:

(A) An individual must be determined eligible for brokerage and support services as described in OAR 411-340-0100; and

(B) The individual must choose to receive services from a Brokerage operating in the geographic service area of the county of origin.

(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 brokerage and support services.

(c) The Brokerage may not accept individuals for entry beyond the total number of individuals specified in the current contract between the Brokerage and the Department.

(2) The Brokerage must make accurate, up-to-date, information about the Brokerage available to individuals referred for services and the legal or designated representatives of individuals. This information must include:

(a) A declaration of Brokerage philosophy;

(b) A declaration of Brokerage employees' responsibilities as mandatory abuse reporters;

(c) 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 organizational structure of the Brokerage;

(B) A description of any contractual relationships the Brokerage has in place, or may establish, to accomplish the functions required by rule; and

(C) A description of the relationship between the Brokerage and the Policy Oversight Group of the brokerage.

(3) The Brokerage must ensure that all individuals eligible for and receiving developmental disabilities services are enrolled in the Department payment and reporting systems.

(4) Individuals are not eligible for services by more than one Brokerage at any one time.

(5) EXIT.

(a) An individual must exit a Brokerage:

(A) When the individual is exited from case management services as described in OAR 411-415-0030; or

(B) Before the individual enrolls in a residential program.

(b) In the event an individual exits a Brokerage, a written Notification of Planned Action must be provided as described in OAR 411-340-0060 and OAR chapter 411, division 318.

(c) Each Brokerage must have policies and procedures for notifying the CDDP of the county of origin of an individual when the individual plans to exit, or exits, brokerage or support services. Notification method, timelines, and content must be based on agreements between the Brokerage and the CDDP of each county in which the Brokerage provides services.

(d) The Brokerage must terminate an individual in the Department payment and reporting systems when an individual exits all developmental disabilities services.

(6) When an individual may have long-term support needs that require enrollment into a residential program:

(a) The Brokerage must provide timely notification to the CDDP of the county of origin of the individual;

(b) The Brokerage must coordinate with the CDDP to facilitate a timely exit from the Brokerage and entry into appropriate, alternative services; and

(c) The Brokerage must assure that information required for a potential operator of a residential program is available as needed for a referral to be made.

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695
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; SPD 13-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 26-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 44-2014, f. 12-26-14, cert. ef. 12-28-14; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0120
Brokerage and Support Services

(1) Each Brokerage must provide or arrange for the following services as required to meet individual support needs:

(a) Case management as described in OAR chapter 411, division 415; and

(b) Assistance with development and expansion of community resources required to meet the support needs of individuals served by the Brokerage.

(2) PARTICIPATION IN PROTECTIVE SERVICES. The Brokerage and personal agent are responsible for the delivery of protective services, in cooperation with the CDDP when necessary, through the timely completion of activities necessary to address immediate health and safety concerns.

Stat. Auth.: ORS 409.050, 427.402 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695
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; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 26-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 44-2014, f. 12-26-14, cert. ef. 12-28-14; APD 32-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

411-340-0150
Standards for 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 and family members of individuals.

(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) QUALITY ASSURANCE.

(a) The Policy Oversight Group must develop a Quality Assurance Plan and review the 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 individuals, legal or designated representatives, professionals, and other sources to determine community support needs and preferences;

(B) Involves individuals in ongoing evaluation of the quality of his or her 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 the 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.

(3) 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 the objectives of the Brokerage and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 409.050, 427.402 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 427.400–427.410, 430.610, 430.620 & 430.662–430.695

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 309-041-1890, 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; SPD 50-2013, f. 12-27-13, cert. ef. 12-28-13; APD 26-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 44-2014, f. 12-26-14, cert. ef. 12-28-14; APD 32-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 15-2016, f. 6-28-16, cert. ef. 6-29-16

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Rule Caption: ODDS: Community Developmental Disabilities Programs (CDDPs)
Adm. Order No.: APD 16-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 5-1-2016
Rules Amended: 411-320-0010, 411-320-0020, 411-320-0030, 411-320-0040, 411-320-0050, 411-320-0070, 411-320-0080, 411-320-0170, 411-320-0180
Rules Repealed: 411-320-0060, 411-320-0090, 411-320-0100, 411-320-0110, 411-320-0120, 411-320-0130, 411-320-0150, 411-320-0160
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is proposing to permanently update the rules for Community Developmental Disabilities Programs (CDDPs) in OAR chapter 411, division 320 to make permanent the following temporary changes that became effective on January 1, 2016:

- To provide consistency and streamline definitions across services, the Department removed general definitions included in OAR 411-317-0000.

- To implement Senate Bill 659, the Department prescribed a process for CDDPs to follow when a child, who is not a resident of Oregon, seeks services while visiting a parent, who is a resident of Oregon, for six weeks of the year or more.

- To implement Senate Bill 97, the Department prescribed a process to reinstate services upon a child's return to Oregon after a temporary absence if the temporary absence of the child was due to the child's parent's military obligation.

- To clarify eligibility determinations, the Department specified:

Eligibility is based on the full criteria for the diagnosis of a developmental disability; and

Eligibility determinations for children less than 7 years of age must be based on an early childhood assessment if the assessment is within one year of intake.

In addition, the Department is restructuring the rules in OAR chapter 411, division 320 to ensure uniform standards for case management, provide more consistency, consolidate requirements, and remove redundancies. Specifically, the Department is:

- Removing the requirements now found in OAR chapter 411, division 415 related to the delivery of case management services and other service access activities, including requirements for CDDP employees who deliver case management services (services coordinators);

- Consolidating CDDP program and contract requirements and incorporate CDDP requirements currently located in other rule divisions;

- Including correct references to OAR chapter 411, division 318 for individual rights to ensure uniform standards related to individual rights across all types of entities involved in the delivery of developmental disabilities services;

- Incorporating Department payment and reporting system requirements for CDDPs;

- Repealing OAR 411-320-0160 for crisis diversion services to reflect current processes;

- Updating training requirements and staff duties to align with current practice;

- Adding qualifications, training requirements, and duties for a foster care licensor and certifier; and

- Reflecting current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-320-0010
Statement of Purpose

The rules in OAR chapter 411, division 320 prescribe general administrative standards for the operation of a community developmental disabilities program (CDDP).

(1) A CDDP providing developmental disabilities services under a contract with the Department is required to meet the basic management, programmatic, and health, safety, and human rights regulations in the management of the community service system for individuals with intellectual or developmental disabilities.

(2) These rules prescribe the standards by which the Department provides services operated by the CDDP, including but not limited to eligibility determination and adult protective services.

Stat. Auth.: ORS 409.050 & 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 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 9-2009, f. & cert. ef. 7-13-09; SPD 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 16-2016, f. 6-28-16, cert. ef. 6-29-16

411-320-0020
Definitions and Acronyms

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 320:

(1) "ABAS" means "Adaptive Behavior Assessment System".

(2) "ABES" means "Adaptive Behavior Evaluation Scale".

(3) "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 normed, standardized tests administered by a licensed clinical or school psychologist, or a doctor of medicine or doctor of osteopathic medicine with specific training and experience in test interpretation of adaptive behavior scales for individuals with intellectual or developmental disabilities. Adaptive behavior assessments include:

(A) Adaptive Behavior Assessment System (ABAS);

(B) Adaptive Behavior Evaluation Scale (ABES);

(C) Vineland Adaptive Behavior Scale (VABS);

(D) Scales of Independent Behavior-Revised (SIB-R); or

(E) Other assessments that are designed to measure adaptive behavior standardized and normed to a population consistent with the population of the applicant or approved by the Department of Human Services, Office of Developmental Disabilities Services (ODDS).

(b) DOMAIN SCORES. Adaptive behavior domain scores are identified on the following assessments of adaptive behavior:

(A) The ABAS and ABES are:

(i) Conceptual;

(ii) Practical; and

(iii) Social.

(B) The VABS are:

(i) Socialization;

(ii) Daily living skills;

(iii) Communication; and

(iv) Motor.

(C) The SIB-R are:

(i) Personal living skills;

(ii) Social interaction and communication skills;

(iii) Community living skills; and

(iv) Motor skills.

(c) COMPOSITE SCORE. The adaptive behavior composite score is the overall score which results from summing two or more domain scores on a given adaptive behavior assessment.

(d) SKILLED AREAS. Skilled areas are a particular assessed score. The skilled areas on the ABAS or ABES are the only skilled areas used for the purposes of OAR 411-320-0080 and include scaled scores in:

(A) Communication;

(B) Functional academics;

(C) Self-direction;

(D) Leisure;

(E) Social;

(F) Community use;

(G) Home and school living;

(H) Self-care;

(I) Health and safety; and

(J) Work.

(e) "Significant impairment" in adaptive behavior means:

(A) A composite score of at least two standard deviations below the norm;

(B) Two or more domain scores as identified in subsection (b) of this section are at least two standard deviations below the norm; or

(C) Two or more skilled areas as identified in subsection (d) of this section are at least two standard deviations below the norm.

(4) "CDDP" means "Community Developmental Disabilities Program".

(5) "CIIS" means "Children's Intensive In-Home Services".

(6) "CMS" means "Centers for Medicare and Medicaid Services".

(7) "Completed Application" means an application required by the Department that:

(a) Is filled out completely, signed, and dated. An applicant who is unable to sign may sign with a mark, witnessed by another person; and

(b) Contains documentation required to make an eligibility determination as outlined in OAR 411-320-0080(1)(a)(B).

(8) "Composite Score" means the score identified by an assessment of adaptive behavior as described in the definition for "adaptive behavior".

(9) "County of Origin" means:

(a) For an adult, the county of residence for the adult; and

(b) For a child, the county where the jurisdiction of guardianship exists.

(10) "Current Documentation" means documentation relating to the intellectual or developmental disabilities of an individual in regards to the functioning of the individual within the last three years. Current documentation may include, but is not limited to, an ISP, Annual Plan, Behavior Support Plan, required assessments, educational records, medical assessments related to the intellectual or developmental disabilities of an individual, psychological evaluations, and assessments of adaptive behavior.

(11) "Developmental Disability" means a neurological condition that:

(a) Originates before an individual is 22 years of age or 18 years of age for an intellectual disability;

(b) Originates in and directly affects the brain and has continued, or is expected to continue, indefinitely;

(c) Constitutes significant impairment in adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080;

(d) Is not primarily attributed to other conditions including, but not limited to, a mental or emotional disorder, sensory impairment, motor impairment, substance abuse, personality disorder, learning disability, or Attention Deficit Hyperactivity Disorder (ADHD); and

(e) Requires training and support similar to an individual with an intellectual disability as described in OAR 411-320-0080.

(12) "Domain Score" means the score identified by an assessment of adaptive behavior as described in the definition for "adaptive behavior".

(13) "Eligibility Determination" means a decision by the CDDP or by the Department regarding the eligibility of a person for developmental disabilities services pursuant to OAR 411-320-0080 and is either a decision that a person is eligible or ineligible for developmental disabilities services.

(14) "Eligibility Specialist" means an employee of the CDDP, or other agency, that contracts with the county or Department to determine eligibility for developmental disabilities services.

(15) "History" means, for the purposes of an eligibility determination as defined in this rule, necessary evidence of an intellectual disability prior to 18 years of age or an other developmental disability prior to 22 years of age, including previous assessments and medical evaluations prior to the date of eligibility determination for developmental disabilities services.

(16) "IEP" means "Individualized Education Program".

(17) "Informal Adaptive Behavior Assessment" means:

(a) Observations of impairment in adaptive behavior recorded in the progress notes for an individual by a services coordinator or a trained eligibility specialist with at least two years of experience working with individuals with intellectual or developmental disabilities; or

(b) A standardized measurement of adaptive behavior, such as a Vineland Adaptive Behavior Scale (VABS) or Adaptive Behavior Assessment System (ABAS), 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 with intellectual or developmental disabilities.

(18) "Intake" means the activity of completing the DD Intake Form (APD 0552) and necessary releases of information prior to the submission of a completed application to the CDDP.

(19) "Intellectual Disability (ID)" means significantly subaverage general intellectual functioning defined as full scale intelligence quotients (IQs) 70 and under as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior directly related to an intellectual disability as described in OAR 411-320-0080 that is manifested during the developmental period prior to 18 years of age. Individuals with a valid full scale IQ of 71-75 may be considered to have

an intellectual disability if there is also significant impairment in adaptive behavior as diagnosed and measured by a licensed clinical or school psychologist as described in OAR 411-320-0080.

(20) "Intellectual Functioning" means functioning as assessed by one or more of the individually administered general intelligence tests developed for the purpose of measuring intelligence. For purposes of making eligibility determinations, intelligence tests do not include brief intelligence measurements.

(21) "IQ" means intelligence quotient.

(22) "ISP" means "Individual Support Plan".

(23) "Licensed Medical Practitioner" means any of the following licensed professionals:

(a) Medical Doctor (MD);

(b) Doctor of Osteopathic Medicine (DO);

(c) Licensed Clinical Psychologist (Ph.D or Psy.D);

(d) Nurse Practitioner (NP);

(e) Physician Assistant (PA); or

(f) Naturopathic Doctor (ND).

(24) "LMHA" means "Local Mental Health Authority".

(25) "Management Entity" means the CDDP or private corporation that operates the Regional Program, including acting as the fiscal agent for regional funds and resources.

(26) "Military Service" means service in the Armed Forces of the United States, as defined in ORS 341.496.

(27) "Motor Impairment" means impairment in the ability to move caused by trauma, disease, or any condition affecting the muscular-skeletal system, spinal cord, or sensory or motor nerves.

(28) "OAAPI" means the "Department of Human Services, Office of Adult Abuse Prevention and Investigation".

(29) "OCCS" means the "Oregon Health Authority, Office of Client and Community Services."

(30) "OHP" means Oregon Health Plan.

(31) "OIS" means "Oregon Intervention System".

(32) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(33) "Qualified Professional" means, for the purposes of OAR 411-320-0080, any of the following licensed professionals trained to make a diagnosis of a specific intellectual or developmental disability:

(a) Licensed clinical psychologist (Ph.D., Psy.D.);

(b) Medical doctor (MD);

(c) Doctor of Osteopathic Medicine (DO); or

(d) Nurse Practitioner (NP).

(34) "Quality Management Strategy" means the Department Quality Assurance Plan for meeting the CMS waiver quality assurances as required and defined by 42 CFR 441.301 and 441.302 and State Plan K option quality assurances as required and defined by 42 CFR 441.585.

(35) "Region" means a group of Oregon counties defined by the Department that have a designated management entity to coordinate regional backup services and be the recipient and administration of funds for those services.

(36) "Regional Program" means the regional coordination that the counties comprising the region agree are delivered more effectively or automatically on a regional basis.

(37) "Resident" means an individual that meets the residency requirements in OAR 461-120-0010. "Resident" includes an individual that is absent due to military obligation, if he or she intends to return Oregon, and Oregon remains his or her principal establishment, home of record, or permanent home during the absence.

(38) "Service Member" means a person who is in the military service or who has separated from military service in the previous 18 months through retirement, discharge, or other separation.

(39) "SIB-R" means "Scales of Independent Behavior-Revised".

(40) "Significantly Subaverage" means a score on a test of intellectual functioning that is two or more standard deviations below the mean for the test.

(41) "Skilled Areas" means a particular assessed score as described in the definition for "adaptive behavior".

(42) "SSI" means "Supplemental Security Income".

(43) "These Rules" mean the rules in OAR chapter 411, division 320.

(44) "U.S. Citizen" means an individual that meets the criteria in OAR 461-120-0110. A U.S. Citizen includes:

(a) An individual born in the United States, Puerto Rico, Guam, Northern Mariana Islands, Virgin Islands, American Samoa, or Swains Island;

(b) A foreign-born child less than 18 years of age residing in the United States with his or her birth or adoptive parents, at least one of whom is a U.S. citizen by birth or naturalization;

(c) An individual granted citizenship status by Immigration and Naturalization Services (INS);

(d) A qualified non-citizen as described in OAR 461-120-0125;

(e) A citizen of Puerto Rico, Guam, Virgin Islands, or Saipan, Tinian, Rota, or Pagan of the Northern Mariana Islands;

(f) A national from American Samoa or Swains Island; or

(g) An alien who is a victim of a severe form of trafficking in persons under section 107(b)(a)(A) of the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).

(45) "VABS" means "Vineland Adaptive Behavior Scale".

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662 - 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; SPD 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 23-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 41-2014, f. 12-26-14, cert. ef. 12-28-14; APD 36-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 16-2016, f. 6-28-16, cert. ef. 6-29-16

411-320-0030
Organization and Program Management

(1) ORGANIZATION AND INTERNAL MANAGEMENT. Each service provider of community developmental disabilities services funded by the Department must have written standards governing the operation and management of the CDDP. 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 CDDP;

(b) Position descriptions for all staff providing community developmental disabilities 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 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 CMS' waiver quality assurances as required by 42 CFR 441.301 and 441.302.

(3) The CDDP must have and implement written policies and procedures that protect the individual rights described in OAR 411-318-0010.

(4) PROGRAM MANAGEMENT.

(a) Staff delivering developmental disabilities services must be organized under the leadership of a designated CDDP manager and receive clerical services sufficient to perform their required duties.

(b) 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 disabilities services within a specific geographic service area.

(c) In addition to other duties as may be assigned in the area of developmental disabilities 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 legal and designated representatives, families, service providers, support services brokerages, the Department, local government, and other state and local agencies with an interest in developmental disabilities 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 information needed to license foster homes, collect federal funds supporting services, and investigate 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 disabilities services.

(5) 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) The CDDP manager must have knowledge of the public service system for developmental disabilities 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 of experience with at least two of those years of experience in developmental disabilities 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 disabilities 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 a 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 (8) 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. The CDDP supervisor (when designated) must have knowledge of the public service system for developmental disabilities 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 disabilities 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 disabilities services.

(c) SERVICES COORDINATOR. The services coordinator must meet the qualifications for a case manager described in OAR 411-415-0040.

(d) ELIGIBILITY SPECIALIST. The eligibility specialist must have knowledge of the public service system for developmental disabilities services in Oregon and at least:

(A) A bachelor's degree in behavioral science, social science, or a closely related field;

(B) A bachelor's degree in any field and one year of human services related experience;

(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. The abuse investigator specialist must have at least:

(A) A bachelor's degree in human science, social science, behavioral science, or criminal science and two years of human services, law enforcement, or investigative experience; or

(B) An associate's degree in human science, social science, behavioral science, or criminal science and four years of human services, law enforcement, or investigative experience.

(f) FOSTER CARE LICENSING AND CERTIFICATION SPECIALIST. A foster care licensing and certification specialist must have knowledge of the public service system for developmental disabilities services in Oregon and at least:

(A) A master's degree in social work;

(B) A bachelor's degree in behavioral science, social work, social science, or a closely related field;

(C) A bachelor's degree in any field and one year of human services related experience, such as 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, or housing;

(D) An associate's degree in a behavioral science, social science, or a closely related field and two years of human services related experience, such as 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, or housing; or

(E) Three years of human services related experience, such as 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, or housing.

(6) EMPLOYMENT APPLICATION. An application for employment at the CDDP must inquire whether an applicant has had any founded reports of child abuse or substantiated abuse.

(7) 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, who has or shall have contact with a recipient of CDDP services, must have an approved background check in accordance with OAR 407-007-0200 to 407-007-0370 and ORS 181.534.

(A) 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 shall 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) 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 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 that remain in the current position for which the employee was hired.

(8) VARIANCE. The CDDP must submit a written variance request to the Department prior to employing a person not meeting the minimum qualifications in section (5) of this rule. A variance request may not be requested for sections (6) and (7) 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 (5) 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.

(9) 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 chapter 411, division 415;

(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 disabilities services;

(B) Completing eligibility redetermination for individuals requesting continuing developmental disabilities 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 disabilities 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.

(d) FOSTER CARE LICENSOR AND CERTIFIER DUTIES. The duties of the foster care licensor and certifier must be specified in the employee's job description and at a minimum include:

(A) In coordination with the Office of Licensing and Regulatory Oversight (OLRO), assist in the initial licensing and certification and renewals of licenses and certifications, of local adult foster homes as described in OAR chapter 411, division 360 and children's foster homes as described in OAR chapter 411, division 346.

(i) Assuring completed application forms from applicants are submitted to OLRO.

(ii) Completing and submitting inspection reports.

(iii) Completing and submitting background checks, as needed.

(iv) Making test sites available, administering tests provided by the Department and sending completed tests to the Department for scoring.

(v) Maintaining a link to the Adult Foster Home Training website where the Basic Training Course, self-study manual, and associated information are maintained and distributing information upon request.

(vi) Assisting in completing any other information necessary for licensing or certifying homes.

(B) Complete foster home visits for rule compliance, issue violation citations, and monitor for correction.

(C) Coordinate the recruitment, retention, placement, and training of foster providers.

(e) Staff must appear as a witness on behalf of the Department during an informal conference and hearing when required by the Department. Staff may not act as a representative for the claimant during an informal conference and hearing.

(10) 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) The CDDP manager and CDDP supervisor (when designated) must complete Core Competencies for case management within the first year of entering into the position.

(b) The CDDP manager and CDDP supervisor (when designated) must continue to enhance his or her knowledge, as well as maintain a basic understanding of developmental disabilities services and the skills, knowledge, and responsibilities of the staff they supervise.

(A) Each CDDP manager and CDDP supervisor (when designated) 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.

(B) Each CDDP manager and CDDP supervisor (when designated) must attend trainings to maintain a working knowledge of system changes in the area the CDDP manager is managing or supervising.

(c) SERVICES COORDINATOR TRAINING. The services coordinator must participate in the case manager training as described in OAR 411-415-0040.

(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 disabilities 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, Social Security Administration, home and community-based waiver and 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, older adults, individuals with physical disabilities, 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 OAAPI. 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 disabilities 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, Social Security Administration, home and community-based waiver 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, older adults, individuals with physical disabilities, 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 OAAPI 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) FOSTER CARE LICENSOR AND CERTIFIER TRAINING. The foster care licensor and certifier must participate in any Department required trainings.

(A) The orientation provided by a CDDP to a new foster care licensor and certifier must include:

(i) An overview of developmental disabilities 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 of policy and procedures that address conflict of interests, including the prohibition against licensing or certifying a foster home:

(I) While also providing case management services to the individuals or children in the home.

(II) By a licensor or certifier who is related by blood, marriage, or adoption to the foster care applicant or current foster provider, or an individual or child to be served in the foster home.

(III) If after a local CDDP assessment of any conflict of interest or appearance of conflict of interest is identified.

(B) A review (prior to having contact with individuals) of the licensor and certifier's responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, older adults, individuals with physical disabilities, and children.

(g) DOCUMENTATION. The CDDP must keep documentation of required training in the personnel files of the individual employees including the CDDP manager, CDDP supervisor (when designated), services coordinator, eligibility specialist, abuse investigator specialist, and other employees providing services to individuals.

(11) 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 the individuals' families.

(c) The advisory committee must advise the LMHA, CDDP director, and 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, CDDP director, and 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.

(12) 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.

(13) FINANCIAL MANAGEMENT.

(a) There must be up-to-date accounting records for each developmental disabilities 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.

(a) The CDDP must have procedures for the ongoing involvement of individuals and their requested family member or other representative in the planning and review of consumer satisfaction with the delivery of case management 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 families of individuals;

(C) Legal or designated representatives (as applicable) and providers of individuals; and

(D) The Department.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662 - 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; SPD 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 16-2016, f. 6-28-16, cert. ef. 6-29-16

411-320-0040
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 disabilities services on the basis of race, color, creed, gender, 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) The CDDP must ensure that eligibility for developmental disabilities services is determined as described in OAR 411-320-0080 by an eligibility specialist trained in accordance with OAR 411-320-0030.

(c) Any individual determined eligible for developmental disabilities services by the CDDP must also be eligible for any developmental disabilities services subject to eligibility requirements described in the OAR associated with the service.

(2) COORDINATION OF SERVICES.

(a) 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 providers as appropriate for the needs of the individual.

(b) NONRESIDENT CHILDREN.

(A) The CDDP must compile and maintain a list of local providers who are qualified to provide home and community-based services in their service area. CDDPs shall assist a parent in obtaining home and community-based services for the parent's child if:

(i) The parent resides in Oregon;

(ii) The parent has a child who does not reside in Oregon but who visits the parent in Oregon for at least six weeks each year; and

(iii) The child qualifies for home and community-based services in the child's state of residence.

(B) CDDP ASSISTANCE. CDDPs shall:

(i) Provide the parent with a list of local providers;

(ii) Contact the state Medicaid agency in the child's state of residence to facilitate payment for the home and community-based services;

(iii) Assist the parent in providing any documentation required by the child's state of residence; and

(iv) Notify the Department of the individual seeking services.

(3) PAYMENT AND REPORTING SYSTEM.

(a) ENROLLMENT. The CDDP must ensure all individuals determined to be eligible for developmental disabilities services are enrolled in the Department payment and reporting systems. The county of origin must enroll the individual into the Department payment and reporting systems for all developmental disabilities service except in the following circumstances:

(A) The Department completes the enrollment or termination for children entering or leaving a licensed 24-hour residential setting that is directly contracted with the Department.

(B) The Department completes the enrollment, termination, and billing forms for children entering or leaving CIIS.

(C) When an individual is enrolled in a Brokerage and the individual moves from one CDDP geographic service area to another CDDP geographic service area, the new CDDP must enroll the individual in the Department payment and reporting systems.

(b) The CDDP must terminate an individual in the Department payment and reporting systems when an individual exits all developmental disabilities services.

(c) The CDDP retains responsibility for maintaining enrollment in the Department payment and reporting systems for individuals enrolled in support services until the individual exits support services.

(4) CASE MANAGEMENT SERVICES.

(a) The CDDP must deliver case management, as described in OAR chapter 411, division 415, to individuals who are eligible for and desire case management from the CDDP. A 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) For an individual newly determined eligible for developmental disabilities services, the CDDP must assure that the individual and legal representative are provided a description of case management and other service delivery options. This information must include:

(A) A description of processes involved in using developmental disabilities services, including person-centered planning, evaluation, and how to raise and resolve concerns about developmental disabilities services;

(B) Clarification of CDDP employee responsibilities as mandatory abuse reporters; and

(C) Disclosure of any potential affiliation between the CDDP and providers available to the individual.

(5) ABUSE INVESTIGATIONS.

(a) 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, including the investigation of complaints of abuse, writing investigation reports, and monitoring the implementation of report recommendations. When there is reason to believe a crime has been committed, the CDDP must report to law enforcement.

(b) The CDDP must report any suspected or observed abuse of a child directly to the Department or local law enforcement.

(6) FOSTER HOMES. When there is need for additional foster care providers, the CDDP must recruit applicants to operate foster homes 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 foster home;

(d) Documentation of references, classification information, credit check (if necessary), background check, and training for 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 annual license or certificate for the foster home.

(7) 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.

(8) 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 disabilities service provider agencies in the county and any Department 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.

(9) Civil commitment services must be provided in accordance with ORS 427.215 to 427.306.

(10) The CDDP must forward a signed variance request form submitted by a developmental disabilities service provider to the Department within 30 days from the receipt of the request indicating the position of the CDDP on the proposed variance.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662 - 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; SPD 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 23-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 41-2014, f. 12-26-14, cert. ef. 12-28-14; APD 36-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 16-2016, f. 6-28-16, cert. ef. 6-29-16

411-320-0050
Management of Regional Services

(1) INTERGOVERNMENTAL AGREEMENT. The management entity for a group of counties to deliver community training, quality assurance activities, or other services, must have an intergovernmental agreement with each affiliated CDDP.

(2) REGIONAL PLAN. The CDDP or private corporation acting as the management entity for the region must prepare, in conjunction with affiliated CDDP's, a plan detailing the services that are to be administered regionally. The regional plan must be updated when needed and submitted to the Department for approval. The regional plan must include:

(a) A description of how services are to be administered;

(b) An organizational chart and staffing plan; and

(c) A detailed budget, on forms provided by the Department.

(3) IMPLEMENTATION. The CDDP or private corporation acting as the management entity for the region must work in conjunction with the affiliated CDDP's to implement the regional plan as approved by the Department, within available resources.

(4) MANAGEMENT STANDARDS. The region, through the management entity and the affiliated CDDP partners, must maintain compliance with the management standards outlined in OAR 411-320-0030 and this rule.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662 - 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 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 16-2016, f. 6-28-16, cert. ef. 6-29-16

411-320-0070
Service Records

(1) CONFIDENTIALITY. The service record for an individual must be kept confidential in accordance with ORS 179.505, 192.515, 192.517, 192.553, 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 CDDPs responsible for the services of the individual, consistent with state statutes and federal laws and regulations concerning confidentiality and privacy.

(3) RECORD REQUIREMENTS. In order to meet Department and federal record documentation requirements, the CDDP, through the employees of the CDDP, must maintain a service record for each individual who receives services from the CDDP. Information contained in the service record must include:

(a) Documentation of any initial referral to the CDDP for services;

(b) The application for developmental disabilities services. The application for developmental disabilities 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;

(c) Sufficient documentation to conform to Department eligibility requirements, including notices of eligibility determination;

(d) Documentation of the initial intake interview or home assessment, as well as any subsequent social service summaries;

(e) Documentation of the request for support services and the selection of an available Brokerage within the geographic service area of the CDDP;

(f) For individuals receiving case management services from the CDDP, the service record must contain the records requirements identified in OAR 411-415-0110.

(4) RETENTION OF RECORDS. The CDDP must have a record retention plan for all records relating to the provision of, and contracts for, CDDP 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 at least 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 death of an individual, if known. If the case is closed, inactive, or the date of death is unknown, the individual service record must be kept for 70 years.

(c) Copies of annual ISPs must be kept for 10 years.

(5) TRANSFER OF RECORDS. In the event an individual moves from one county to another county in Oregon, the complete service record for an individual 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 service record required by this rule is maintained in permanent record and transferred to the CDDP having jurisdiction for the services for the individual. The sending CDDP must retain the following information to document that services were provided to the individual while enrolled in CDDP services:

(a) Documentation of eligibility for developmental disabilities services received while enrolled in services through the CDDP, including waiver or state plan eligibility;

(b) Service enrollment and termination forms;

(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 Department.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662 - 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; SPD 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 41-2014, f. 12-26-14, cert. ef. 12-28-14

411-320-0080

Application and Eligibility Determination

(1) APPLICATION.

(a) To apply for developmental disabilities services:

(A) An applicant or the legal representative of the applicant must submit a completed application as defined in OAR 411-320-0020 to the CDDP in the county of origin as defined in OAR 411-320-0020;

(B) The CDDP must receive all documentation required to make an eligibility determination as defined in OAR 411-320-0020. Documentation includes, but is not limited to:

(i) School psychological or comprehensive evaluations since entry into school;

(ii) Medical assessments related to a disability, mental health condition, or physical impairment;

(iii) Psychological evaluations or comprehensive evaluations through private health insurance or other programs;

(iv) Neurological evaluations completed through any entity;

(v) Records from all residential or psychiatric facilities;

(vi) Records completed through application process for other governmental benefits; and

(vii) Administrative medical examinations and reports, as defined in OAR 410-120-0000, determined necessary and authorized by the eligibility specialist.

(C) The applicant or the legal representative of the applicant must provide documentation of U.S. citizenship as defined in OAR 411-320-0020; and

(D) The applicant must reside in Oregon or if the applicant is less than 18 years of age, the applicant and the legal representative of the applicant must reside in Oregon.

(b) The CDDP may stop the intake process if the documents listed in subsection (a)(B) of this section are not submitted within 90 days of the date that the CDDP received the signed and dated Intake Form (APD 0552). If the CDDP stops the intake process, written notice of the information needed to determine eligibility or a withdrawal letter must be sent to the person identified on the Intake Form (APD 0552) as the person seeking services and the legal representative of the person seeking services.

(c) The CDDP must consider an application if the criteria in subsection (a) of this section are met. If the criteria in subsection (a) of this section are not met, the CDDP shall deny the application by sending a Notification of Planned Action (APD 0947).

(d) Upon receipt of a completed application, the CDDP must provide an applicant the Department required Notification of Rights (form APD 0948) within 10 business days.

(e) A new application may not be required if the file for an individual has been closed for less than 12 months following a closure, denial, or termination and the individual meets all of the criteria in subsection (a) of this section.

(f) The CDDP must identify whether an applicant receives any income.

(A) The CDDP must refer all applicants not currently receiving an OCCS medical package to the local Medicaid office for application and benefit determination.

(B) The CDDP must refer an applicant less than 18 years of age to Social Security if the CDDP identifies that the applicant may qualify for Social Security benefits.

(g) REINSTATEMENT OF ELIGIBILITY FOR CHILDREN OF SERVICE MEMBERS.

(A) WAIVER OF APPLICATION. A previously eligible child of a service member, who temporarily left Oregon due to a parent's military service obligation outside of Oregon, does not need to submit a new application for developmental disabilities services upon return. Upon return to Oregon and a request to a CDDP in the county of origin, the CDDP in the county of origin shall assign a services coordinator within 10 days of the request for services.

(B) COORDINATION OF SERVICES. The services coordinator must assist the child in establishing eligibility for OSIPM or OCCS medical coverage and meet face-to-face with the child and guardian, within 45 days of the request for services, to provide choice advising and to review the child's rights to a fair hearing and the service planning steps in OAR 411-415-0070.

(C) REDETERMINATION. The CDDP must follow section (5) and (6) of this rule regarding a redetermination of eligibility. As with all redeterminations, prior to a termination of developmental disabilities services, the CDDP must send a notice of redetermination, afford the child's parent or guardian the opportunity to provide documentation that supports eligibility, and schedule a diagnostic evaluation for the child, if appropriate. Upon the child's reentry to services, the CDDP in the county of origin shall initiate a redetermination if:

(i) The criteria used to determine eligibility for developmental disabilities services changed during the child's absence;

(ii) There are new records related to the eligibility criteria for developmental disabilities services, including medical, psychological, or school records related to an intellectual or developmental disability; or

(iii) The documents used to establish the child's original eligibility are more than three-years-old and medical, educational, or psychological records created during the child's absence do not support the child's eligibility for developmental disabilities services.

(2) ELIGIBILITY SPECIALIST. Each CDDP must identify at least one qualified eligibility specialist to act as a designee of the Department for purposes of making an eligibility determination. The eligibility specialist must meet performance qualifications and training expectations for determining eligibility for developmental disabilities services according to OAR 411-320-0030.

(3) INTELLECTUAL DISABILITY. A history of an intellectual disability as defined in OAR 411-320-0020 and significant impairment in adaptive behavior as described in OAR 411-320-0020 must be evident prior to the 18th birthday of an individual for the individual to be eligible for developmental disabilities services.

(a) Diagnosing an intellectual disability is done by measuring intellectual functioning and adaptive behavior as assessed by standardized tests administered by a licensed clinical or school psychologist with specific training and experience in test interpretation of intellectual functioning and adaptive behavior scales for individuals with intellectual disabilities.

(A) For individuals who have consistent and valid Full Scale IQ results of 65 and less, no assessment of adaptive behavior may be needed if current documentation supports eligibility.

(B) For individuals who have a valid Full Scale IQ or equivalent composite score results of 66-75, verification of an intellectual disability requires an assessment of adaptive behavior.

(C) A General Ability Index result must be used in place of a Full Scale IQ score to determine eligibility if a licensed clinical or school psychologist determines that the General Ability Index is a more valid measure of overall intelligence when compared to the Full Scale IQ score.

(D) A Specific Index IQ result must be used in place of a Full Scale IQ score to determine eligibility if a licensed clinical or school psychologist determines that the Specific Index IQ is a more valid measure of overall intelligence when compared to the Full Scale IQ score.

(E) If an individual is not able to participate in an intelligence test due to intellectual disability, a statement of intellectual disability must be documented by a qualified professional and an adaptive behavior assessment demonstrating a composite score of at least two standard deviations below the mean must be completed.

(b) Impairment of adaptive behavior must be directly related to an intellectual disability and cannot be primarily attributed to other conditions, including but not limited to a mental or emotional disorder, sensory impairment, motor impairment, substance abuse, personality disorder, learning disability, or ADHD.

(c) The condition and impairment must continue, or be expected to continue, indefinitely.

(4) OTHER DEVELOPMENTAL DISABILITY. A history of an other developmental disability as defined in OAR 411-320-0020 and significant impairment in adaptive behavior as described in OAR 411-320-0020 must be evident prior to the 22nd birthday of an individual for the individual to be eligible for developmental disabilities services.

(a) Diagnosing an other developmental disability requires a medical or clinical diagnosis of a developmental disability by a qualified professional and significant impairment in adaptive behavior as assessed by standardized tests administered by a licensed clinical or school psychologist, or a doctor of medicine or doctor of osteopathic medicine with specific training and experience in test interpretation of adaptive behavior scales. The individual must meet the full criteria for the diagnosis of the developmental disability. Individuals with a "provisional", "partial", or "rule-out" diagnosis do not meet the full criteria.

(A) Other developmental disabilities include autism, cerebral palsy, epilepsy, or other neurological disabling conditions that originate in and directly affect the brain.

(B) The individual must require training and support similar to that required by an individual with an intellectual disability, which means the individual has a composite or domain score that is at least two standard deviations below the mean, as measured on a standardized assessment of adaptive behavior administered by a licensed clinical or school psychologist, or a doctor of medicine or doctor of osteopathic medicine with specific training and experience in test interpretation of adaptive behavior scales.

(b) Significant impairment of adaptive behavior must be directly related to an other developmental disability and cannot be primarily attributed to other conditions including, but not limited to, a mental or emotional disorder, sensory impairment, motor impairment, substance abuse, personality disorder, learning disability, or ADHD.

(c) The condition and impairment must continue, or be expected to continue, indefinitely.

(5) ELIGIBILITY FOR CHILDREN LESS THAN 7 YEARS OF AGE.

(a) Eligibility determinations for children less than 7 years of age must be based on documentation that is no more than one year old.

(A) The documentation must include:

(i) A valid standardized-and-normed early-childhood assessment, completed by a professional with at least a master's degree and training to administer early childhood assessments, which demonstrates the functioning of the child is at least two standard deviations below the mean in two or more areas of the adaptive behavior described in paragraph (B) of this subsection; or

(ii) When a standardized-and-normed early-childhood assessment is not available or not completed within one year of the date the CDDP receives the intake form, a medical statement by a licensed medical practitioner that confirms the presence of an other developmental disability that is a neurological condition or syndrome that originates in and directly affects the brain and causes or is likely to cause impairment in at least two or more areas of the adaptive behavior described in paragraph (B) of this subsection.

(B) Areas of adaptive behavior include:

(i) Adaptive, self-care, or self-direction;

(ii) Receptive and expressive language or communication;

(iii) Learning or cognition;

(iv) Gross and fine motor; or

(v) Social.

(C) The impairment, condition, or syndrome cannot be primarily attributed to other conditions including, but not limited to, a mental or emotional disorder, sensory impairment, motor impairment, substance abuse, personality disorder, learning disability, or ADHD.

(D) The condition and impairment must continue, or be expected to continue, indefinitely.

(b) REDETERMINATION OF ELIGIBILITY.

(A) Eligibility for children less than 7 years of age is always provisional.

(i) Redetermination for school aged eligibility for a child who was originally determined eligible as a child less than 7 years of age using a standardized and normed early childhood assessment as described in subsection (b)(A)(i) of this section must be completed no later than the child's 9th year birthdate.

(ii) Redetermination for school aged eligibility for a child who was originally determined eligible as a child less than 7 years of age using a medical statement by a licensed medical practitioner as described in subsection (b)(A)(ii) of this section must be completed no later than the child's 7th year birthdate.

(B) Any time there is evidence that contradicts an eligibility determination, the Department or the designee of the Department may redetermine eligibility or obtain additional information, including securing an additional evaluation for clarification purposes.

(C) The CDDP must notify a child and the legal representative of the child any time that a redetermination of eligibility is needed. Notification of the redetermination and the reason for the review of eligibility must be in writing and sent prior to the eligibility redetermination.

(6) ELIGIBILITY FOR SCHOOL AGED CHILDREN. Eligibility for school aged children as defined in OAR 411-320-0020 is always provisional.

(a) Eligibility determinations for school aged children must be completed on children who are at least 5 years of age and who have had school aged testing completed.

(b) Eligibility determinations for school aged children may be completed:

(A) Up to age 18 for school aged children who are provisionally eligible based on a condition of an intellectual disability; and

(B) Up to age 22 for school aged children who are provisionally eligible based on a condition of an other developmental disability.

(c) Eligibility determinations for school aged children must include:

(A) Documentation of an intellectual disability and significant impairment in adaptive behavior as described in section (3) of this rule; or

(B) A diagnosis and documentation of an other developmental disability and significant impairment in adaptive behavior as described in section (4) of this rule.

(d) Eligibility determinations for school aged children must be based on documentation that is no more than three years old.

(e) REDETERMINATION OF ELIGIBILITY.

(A) Any time there is evidence that contradicts an eligibility determination, the Department or the designee of the Department may redetermine eligibility or obtain additional information, including securing an additional evaluation for clarification purposes.

(B) The CDDP must notify a school aged child and the legal representative of the child any time that a redetermination of eligibility is needed. Notification of the redetermination and the reason for the review of eligibility must be in writing and sent prior to the eligibility redetermination.

(f) REDETERMINATION OF SCHOOL AGED CHILDREN FOR ADULT ELIGIBLITY.

(A) Redetermination of school aged children for adult eligibility must be completed:

(i) Between the ages of 16 and 18 if school aged eligibility was determined based on an intellectual disability as described in section (3) of this rule; or

(ii) Between the ages of 20 and 22 if school aged eligibility was determined based on an other developmental disability as described in section (4) of this rule.

(B) The documentation of an intellectual disability or an other developmental disability must include for individuals less than 22 years of age, information no more than three years old.

(C) If school aged eligibility was determined based on an intellectual disability as described in section (3) of this rule, an intellectual functioning assessment may be used to determine adult eligibility. An adult intellectual functioning assessment completed within the last three years is not needed if the school aged child has:

(i) More than one completed intellectual functioning assessment and all full scale IQ scores are 65 or less as described in section (3)(a)(A) of this rule;

(ii) Impairment in adaptive behavior as identified in section (3) of this rule; and

(iii) Current documentation that supports eligibility.

(D) If school aged eligibility was determined based on an other developmental disability as described in section (4) of this rule, the following criteria must be met:

(i) A current medical or clinical diagnosis of an other developmental disability is required unless all of the following are met:

(I) Documentation of an other developmental disability by a qualified professional as described in section (4) of this rule;

(II) Impairment in adaptive behavior that continues to be directly related to the other developmental disability;

(III) Current documentation that continues to support eligibility; and

(IV) No other medical or mental or emotional disorder.

(ii) If an individual has additional medical or mental or emotional disorders a new assessment may be required.

(iii) An informal adaptive behavior assessment as defined in OAR 411-320-0020 may be completed if all of the following apply:

(I) An assessment of adaptive behavior is required in order to redetermine eligibility;

(II) An assessment of adaptive behavior has already been completed by a licensed school or clinical psychologist; and

(III) The school aged child has obvious significant impairment in adaptive behavior.

(7) ELIGIBILITY FOR ADULTS.

(a) Eligibility for adults must include:

(A) Documentation of an intellectual disability and significant impairment in adaptive behavior as described in section (3) of this rule; or

(B) Documentation of an other developmental disability and significant impairment in adaptive behavior as described in section (4) of this rule.

(b) Documentation for an adult eligibility determination must include:

(A) Information no more than three years old for individuals less than 22 years of age; or

(B) Information obtained after the 17th birthday of an individual for individuals 22 years of age and older.

(c) INTELLECTUAL FUNCTIONING ASSESSMENT.

(A) An intellectual functioning assessment completed on or after the age of 16 may be used to determine adult eligibility.

(B) An adult intellectual functioning assessment may not be needed if an individual has:

(i) More than one completed intellectual functioning assessment and all full scale IQ scores are 65 or less as described in section (3)(a)(A) of this rule; and

(ii) Significant impairment in adaptive behavior as identified in section (3) of this rule.

(C) An adult intellectual functioning assessment may not be needed if an individual has a diagnosis and documentation of an other developmental disability as described in section (4) of this rule.

(d) REDETERMINATION OF ELIGIBILITY.

(A) Any time there is evidence that contradicts an eligibility determination, the Department or the designee of the Department may redetermine eligibility or obtain additional information, including securing an additional evaluation for clarification purposes.

(B) The CDDP must notify an individual and if applicable the legal representative of the individual any time that a redetermination of eligibility is needed. Notification of the redetermination and the reason for the review of eligibility must be in writing and sent prior to the eligibility redetermination.

(C) In the event the eligibility of an adult requires a redetermination, the redetermination must be completed as described in subsections (a), (b), and (c) of this section.

(8) ABSENCE OF DATA IN DEVELOPMENTAL YEARS.

(a) In the absence of sufficient data during the developmental years, current data may be used if:

(A) There is no evidence of head trauma;

(B) There is no evidence or history of significant mental or emotional disorder; or

(C) There is no evidence or history of substance abuse.

(b) If there is evidence or a history of head trauma, significant mental or emotional disorder, or substance abuse, then a clinical impression by a qualified professional regarding how the functioning of the individual may be impacted by the identified condition must be obtained in order to determine if the significant impairment in adaptive behavior is directly related to a developmental disability and not primarily related to a head trauma, significant mental or emotional disorder, or substance abuse.

(9) SECURING EVALUATIONS. In the event that an eligibility specialist has exhausted all local resources to secure the necessary evaluations for an eligibility determination, the Department or the designee of the Department shall assist in obtaining additional testing if required to complete the eligibility determination.

(10) PROCESSING ELIGIBILITY DETERMINATIONS. The CDDP in the county of origin is responsible for making the eligibility determination.

(a) The CDDP must work in collaboration with the individual or the legal representative of the individual to gather historical records related to the intellectual or developmental disability of an individual during intake in order to complete an application for services.

(b) During intake, the CDDP must gather enough information and documentation in order to accept a completed application for developmental disabilities services within 90 days of the date of intake, except in the following circumstances:

(A) The CDDP is unable to obtain a complete application because the individual or the legal representative of the individual does not collaborate with the eligibility specialist or fails to execute an action necessary to obtain a completed application;

(B) There is an emergency beyond the control of the CDDP; or

(C) More time is needed to obtain additional records by the CDDP, the individual, or the legal representative of the individual.

(c) Upon receipt of the completed application, as defined in OAR 411-320-0020, the CDDP must make an eligibility determination unless the following applies and is documented in the progress notes for an individual:

(A) The individual or the legal representative of the individual voluntarily withdraws the application for the individual;

(B) The individual dies; or

(C) The individual cannot be located.

(d) The CDDP may not use the time frames established in subsection (b) of this section as:

(A) A waiting period before determining eligibility; or

(B) A reason for denying eligibility.

(11) NOTICE OF ELIGIBILITY DETERMINATION. Within 10 days from the receipt of a completed application, the CDDP must send or hand deliver a written notification (notice) of the eligibility determination. The notice must be on the following forms prescribed by the Department:

(a) The Notice of Eligibility Determination (form APD 5103); or

(b) The Notification of Planned Action (form APD 0947).

(12) REQUESTING A HEARING. An individual or the legal representative of an individual may request a hearing as described in OAR 411-318-0025 if the individual or the legal representative of the individual disagrees with the eligibility determination or redetermination made by the CDDP.

(13) TRANSFERABILITY OF ELIGIBILITY DETERMINATION. An eligibility determination made by one CDDP must be honored by another CDDP when an individual moves from one county to another.

(a) The receiving CDDP must notify the individual and if applicable the legal representative of the individual on forms prescribed by the Department that a transfer of services to a new CDDP has taken place within 10 days of the enrollment date identified on the Developmental Disabilities Enrollment Form (DHS 0337).

(b) The receiving CDDP must continue services for the individual as soon as it is determined that the individual is residing in the county of the receiving CDDP.

(c) The receiving CDDP must ensure verification of the eligibility of the individual for developmental disabilities services in the form of the following:

(A) Statement of an eligibility determination;

(B) Notification of eligibility determination; and

(C) Evaluations and assessments supporting eligibility.

(d) In the event that the items in subsection (c) of this section cannot be located, written documentation from the sending CDDP verifying eligibility and enrollment in developmental disabilities services may be used. Written verification may include documentation from the electronic payment system of the Department.

(e) If the receiving CDDP receives information that suggests the individual is not eligible for developmental disabilities services, the receiving CDDP may complete a redetermination. The CDDP that determined the individual was eligible for developmental disabilities services may be responsible for the services authorized on the basis of that eligibility determination.

(f) If an individual submits an application for developmental disabilities services and discloses that he or she has previously received developmental disabilities services in another CDDP and the termination of case management services as described in OAR 411-415-0030 occurred within the past 12 months, the eligibility determination from the other CDDP shall transfer as outlined in this section of the rule.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662 - 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 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 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 23-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 41-2014, f. 12-26-14, cert. ef. 12-28-14; APD 36-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 16-2016, f. 6-28-16, cert. ef. 6-29-16

411-320-0170
Contracts and Contractor Disputes

(1) CONTRACTS.

(a) If the CDDP, or any of the CDDPs services as described in the Department's contract with the county, is not operated by the county, there must be a contract between the county 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 rules of the Department pertaining to contracts or any contract requirement with regard to operation and delivery of services.

(b) The CDDP may purchase certain services that are necessary for the CDDP to carry out its operations from a contractor without first providing an opportunity for competition among other contractors.

(A) The contractor 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 rules of the Department 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 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 that disputes arising from these limitations must be resolved according to the complaint procedures contained in section (3) of this rule. 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 contractor 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) As a local option, the CDDP may impose a requirement on a public agency or private corporation delivering developmental disabilities services under a contract with the CDDP 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 is to appear in the contract. The proposed local option must include:

(i) The date upon which the local option is to become effective; and

(ii) A complete written description of how the local option is to improve individual independence, productivity, or integration or 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 Director of the Department 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 is to appear in contracts with service providers, including the proposed date upon which the requirement is to 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.

(2) CONTRACT MONITORING. The CDDP must monitor all community developmental disabilities subcontractors to assure that:

(a) Services are provided as specified in the contract between the CDDP and the Department; and

(b) Services are in compliance with these rules and other applicable Department rules.

(3) When a dispute exists between a CDDP and a subcontracted provider regarding the terms of the contract or the interpretation of administrative rule and local dispute resolution efforts have been unsuccessful, either party may request assistance from the Department in mediating the dispute.

(a) The parties must demonstrate a spirit of cooperation, mutual respect, and good faith in all aspects of the mediation process. Mediation must be conducted as follows:

(A) The party requesting mediation must send a written request to the Director of the Department, the CDDP Director, and the Executive Director of the provider, unless other people are named as official contact people in the specific rule or contract under dispute. The request must describe the nature of the dispute and identify the specific rule or contract provisions that are central to the dispute.

(B) Department staff shall arrange the first meeting of the parties at the earliest possible date. The agenda for the first meeting shall include:

(i) Consideration of the need for services of an outside mediator. If the services of an unbiased mediator are desired, agreement shall be made on arrangements for obtaining these services;

(ii) Development of rules and procedures that shall be followed by all parties during the mediation; and

(iii) Agreement on a date by which mediation shall be completed, unless extended by mutual agreement.

(C) Unless otherwise agreed to by all parties:

(i) Each party shall be responsible for the compensation and expenses of their own employees and representatives; and

(ii) Costs that benefit the group, such as services of a mediator, rental of meeting space, purchase of snack food and beverage, etc. shall be shared equally by all parties.

(b) A written statement documenting the outcome of the mediation must be prepared. This statement must consist of a brief written statement signed by all parties or separate statements from each party declaring their position on the dispute at the conclusion of the mediation process. In the absence of written statements from other parties, the Department shall prepare the final report. A final report on each mediation must be retained on file at the Department.

(4) A provider may appeal the imposition of a disputed term or condition in the contract if the provider believes that the contract offered by the CDDP contains terms or conditions that are not substantially similar to those established by the Department in the model contract. The appeal of the imposition of the disputed terms or conditions must be in writing and sent to the Director of the Department within 30 days after the effective date of the contract requirement.

(a) A copy of the notice of appeal must be sent to the CDDP. The notice of appeal must include:

(A) A copy of the contract and any pertinent contract amendments;

(B) Identification of the specific terms that are in dispute; and

(C) A complete written explanation of the dissimilarity between terms.

(b) Upon receipt of the notice of appeal, the CDDP must suspend enforcement of compliance with any contract requirement under appeal by the provider until the appeal process is concluded.

(c) The Director of the Department must offer to mediate a solution in accordance with the procedure outlined in sections (3)(a) and (3)(b) of this rule.

(A) If a solution cannot be mediated, the Director of the Department shall declare an impasse through written notification to all parties and immediately appoint a panel to consider arguments from both parties. The panel must include, at a minimum:

(i) A representative from the Department;

(ii) A representative from another CDDP; and

(iii) A representative from another provider organization.

(B) The panel must meet with the parties, consider the respective arguments, and send written recommendations to the Director of the Department within 45 business days after an impasse is declared, unless the Director of the Department grants an extension.

(C) If an appeal requiring panel consideration has been received from more than one contractor, the Department may organize materials and discussion in any manner deemed necessary, including combining appeals from multiple contractors, to assist the panel in understanding the issues and operating efficiently.

(D) The Director of the Department must notify all parties of his or her decision within 15 business days from the receipt of the recommendations of the panel. The decision of the Department is final. The CDDP must take immediate action to amend contracts as needed to comply with the decision.

(d) Notwithstanding subsection (c) of this section, the Director of the Department has the right to deny the appeal or a portion of the appeal if, upon receipt and review of the notice of appeal, the Director of the Department finds that the contract language being contested is identical to the current language in the county financial assistance agreement with the Department.

(e) The CDDP or the contractor may request an expedited appeal process that provides a temporary resolution if it can be shown that the time needed to follow procedures to reach a final resolution would cause imminent risk of serious harm to individuals or organizations.

(A) The request must be made in writing to the Director of the Department. The request must describe the potential harm and level of risk that shall be incurred by following the appeal process.

(B) The Department must notify all parties of the decision to approve an expedited appeal process within two business days.

(C) If an expedited process is approved, the Department shall notify all parties of the decision concerning the dispute within three additional business days. The decision resulting from an expedited appeal process shall be binding, but temporary, pending completion of the appeal process. All parties must act according to the temporary decision until notified of a final decision.

Stat. Auth.: ORS 409.050, 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-695

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; Administrative correction 6-28-11; SPD 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 23-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 41-2014, f. 12-26-14, cert. ef. 12-28-14; APD 16-2016, f. 6-28-16, cert. ef. 6-29-16

411-320-0180

Inspections and Investigations

(1) All services covered by these rules must allow the following types of investigations and inspections:

(a) Quality assurance, certification, and on-site inspections;

(b) Complaint investigations; and

(c) Abuse investigations.

(2) The Department or the designee of the Department, the Oregon Health Authority, or proper authority must perform all inspections and investigations.

(3) Any inspection or investigation may be unannounced.

(4) A plan of correction must be submitted to the Department for any non-compliance found during an inspection under this rule.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620 & 430.662 – 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 57-2013, f. 12-27-13, cert. ef. 12-28-13; APD 16-2016, f. 6-28-16, cert. ef. 6-29-16

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Rule Caption: ODDS: Contested Case Hearings and Rights of Individuals Receiving Developmental Disabilities Services

Adm. Order No.: APD 17-2016

Filed with Sec. of State: 6-28-2016

Certified to be Effective: 6-29-16

Notice Publication Date: 4-1-2016

Rules Amended: 411-318-0000, 411-318-0005, 411-318-0010

Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the rights for individuals receiving developmental disabilities services and the process to request a contested case hearing in OAR chapter 411, division 318.

The rules in OAR chapter 411, division 318 are being updated to:

- Make permanent temporary changes that became effective January 1, 2016;

- Incorporate the standards for home and community-based (HCB) services and settings and person-centered service planning adopted by the Department in OAR chapter 411, division 004 to implement the regulations and expectations of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS);

- Clarify that a request for a contested case hearing must be in writing;

- Reflect current Department terminology and the restructuring of the rules relating to developmental disabilities services; and

- Perform minor grammar, punctuation, formatting, and housekeeping changes.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-318-0000

Statement of Purpose and Scope

(1) The rules in OAR chapter 411, division 318 prescribe:

(a) The rights of individuals receiving developmental disabilities services;

(b) The process for reporting and investigating a complaint regarding dissatisfaction with a developmental disabilities service or provider;

(c) The requirements for notification in the event a developmental disabilities service is denied, reduced, suspended, or terminated and the contested case hearing process for challenging a denial, reduction, suspension, or termination of a developmental disabilities service; and

(d) The contested case hearing process for challenging an involuntary reduction, transfer, or exit.

(2) The rules in OAR chapter 411, division 318 apply to the developmental disabilities services and service settings described in OAR chapter 411, divisions 004 and 300 to 450.

Stat. Auth.: ORS 409.050, 427.107

Stats. Implemented: ORS 183.411-471, 409.010, 427.107, 427.109

Hist.: APD 22-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 40-2014, f. 12-26-14, cert. ef. 12-28-14; APD 37-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 17-2016, f. 6-28-16, cert. ef. 6-29-16

411-318-0005

Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 318:

(1) "CDDP" means Community Developmental Disabilities Program.

(2) "Claimant" means the person directly impacted by an action that is the subject of a hearing request.

(3) "Complaint" means an oral or written expression of dissatisfaction with a developmental disabilities service or provider.

(4) "Complaint Investigation" means the investigation of a complaint that has been made to a proper authority that is not covered by an investigation of abuse.

(5) "Complaint Log" means a list of complaint-related information.

(6) "Continuing Services" means the continuation of a developmental disabilities service following the request for a hearing. Services continue until a Final Order is issued.

(7) "DD Administrative Hearing Request" means form SDS 0443DD.

(8) "Denial" means any rejection of a request for a developmental disabilities service or an increase in a developmental disabilities service. A denial of a Medicaid service requires a Notification of Planned Action.

(9) "Department Hearing Representative" means a person authorized by the Department to represent the Department in a hearing as described in OAR 411-001-0500.

(10) "Department Staff" means a person employed by the Department who is knowledgeable in a particular subject matter. For the purposes of the complaint process, Department staff may not be involved in a specific complaint prior to the receipt of the complaint or the request for a review of the complaint.

(11) "Exit" means termination or discontinuance of a Department-funded developmental disabilities service.

(12) "Good Cause" means an excusable mistake, surprise, excusable neglect (which may include neglect due to a significant cognitive or health issue), circumstances beyond the control of a claimant, reasonable reliance

on the statement of an employee of the Department or an adverse provider relating to procedural requirements, [or due to] fraud, misrepresentation, or other misconduct of the Department or a party adverse to a claimant.

(13) "Hearing" means a contested case hearing subject to OAR 137-003-0501 to 137-003-0700, which results in a Final Order.

(14) "Informal Conference" means the discussion between a claimant, the representative of the claimant, Department staff, and a Department representative that is held prior to a hearing to address any matters pertaining to the hearing, as described in OAR 411-318-0025. An administrative law judge does not participate in an informal conference. The informal conference may result in resolution of the issue.

(15) "Informal Discussion" means the conversation between an individual making a complaint, or as applicable the representative of the individual, and the designee of the Department or local program who received the complaint to address the content of the complaint. The informal discussion may result in resolution of the issue.

(16) "Involuntary Reduction" means a provider has made the decision to reduce services provided to an individual without prior approval from the individual.

(17) "Involuntary Transfer" means a provider has made the decision to transfer an individual without prior approval from the individual.

(18) "Local Program" means the case management entity, provider organization, or other certified, licensed, or endorsed provider or agency with which the Department contracts to provide developmental disabilities services and is providing services to the individual with whom a complaint is associated.

(19) "Notice of Involuntary Reduction, Transfer, or Exit" means form SDS 0719DD. This form is part of the AFH/DD Mandatory Written Notice of Exit or Transfer.

(20) "Notification of Planned Action" means form SDS 0947. The Notification of Planned Action is the written decision notice issued to an individual in the event that a developmental disabilities service is denied, reduced, suspended, or terminated.

(21) "OAH" means the Office of Administrative Hearings.

(22) "OHA" means the Oregon Health Authority.

(23) "Program Director" means the Director of a local program or the designee of the Director.

(24) "Program Staff" means a person employed by the local program who is knowledgeable in a particular subject matter. For the purposes of the complaint process, program staff may not be involved in a specific complaint prior to the receipt of the complaint or the request for a review of the complaint.

(25) "Representative" means any adult, such as a parent, family member, guardian, legal representative, advocate, or other person, who is chosen by an individual or the legal representative of the individual to represent the individual in connection with the provision of developmental disabilities services or during the complaint or hearing process. The representative may not be an employee of the Department, CDDP, or Support Services Brokerage acting in official capacity. An individual or the legal representative for the individual is not required to choose a representative.

(26) "Request for Service" means:

(a) Submission of a completed application for developmental disabilities services as described in OAR 411-320-0080;

(b) A written request for a new developmental disabilities service or provider; or

(c) A written request for a change in a developmental disabilities service currently provided.

(27) "Service" means the developmental disabilities services and service settings described in OAR chapter 411, divisions 004 and 300 to 450.

(28) "Service Funds" mean state public funds or Medicaid funds used to purchase developmental disabilities services.

(29) "These Rules" mean the rules in OAR chapter 411, division 318.

(30) "Transfer" means movement of an individual from one service setting to a different service setting administered or operated by the same provider.

(31) "Written Outcome" means the written response from the Department or the local program to a complaint following a review of the complaint.

Stat. Auth.: ORS 409.050, 427.107

Stats. Implemented: ORS 183.411-471, 409.010, 427.107, 427.109

Hist.: APD 22-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 40-2014, f. 12-26-14, cert. ef. 12-28-14; APD 37-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 17-2016, f. 6-28-16, cert. ef. 6-29-16

411-318-0010

Individual Rights

(1) While receiving developmental disabilities services, an individual has the right to:

(a) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

(b) Be free from seclusion, unauthorized training or treatment, and personal, chemical, and mechanical restraints, unless an imminent risk of physical harm to the individual or others exists and only for as long as the imminent risk continues;

(c) Be assured that medication is administered only for the clinical needs of the individual as indicated by a health care provider, unless an imminent risk of physical harm to the individual or others exists and only for as long as the imminent risk continues;

(d) Individual choice for an adult to consent to or refuse treatment unless incapable and then an alternative decision maker must be allowed to consent to or refuse treatment for the adult. For a child, the parent or guardian of the child must be allowed to consent to or refuse treatment, except as described in ORS 109.610 or limited by court order;

(e) Informed, voluntary, written consent prior to receiving services, except in a medical emergency or as otherwise permitted by law;

(f) Informed, voluntary, written consent prior to participating in any experimental programs;

(g) A humane service environment that affords reasonable privacy and the ability to engage in private communications with people chosen by the individual through personal visits, mail, telephone, or electronic means;

(h) Visit with legal and designated representatives, family members, friends, advocates, legal and medical professionals, and others chosen by the individual, except where prohibited by court order;

(i) Participate regularly in the community and use community resources, including recreation, developmental disabilities services, employment services, school, educational opportunities, and health care resources;

(j) For individuals less than 21 years of age, access to a free and appropriate public education, including a procedure for school attendance or refusal to attend;

(k) Not be required to perform labor, except personal housekeeping duties, without reasonable and lawful compensation;

(l) Manage his or her own money and financial affairs unless the right has been taken away by court order or other legal procedure;

(m) Keep and use personal property and have a reasonable amount of personal storage space;

(n) Food, housing, clothing, medical and health care, supportive services, and training;

(o) Seek a meaningful life by choosing from available services and enjoying the benefits of community involvement and community integration in a manner that is most integrated, considering the preferences and age of the individual;

(p) An individualized written plan for services created through a person-centered planning process, services based upon the plan, and periodic review and reassessment of service needs;

(q) Ongoing participation in the planning of services, including the right to participate in the development and periodic revision of the plan for services, the right to be provided with an explanation of all service considerations in a manner that ensures meaningful individual participation, and the right to invite others chosen by the individual to participate in the plan for services;

(r) Request a change in the plan for services and a reassessment of service needs;

(s) A timely decision upon request for a change in the plan for services and a reassessment of service needs;

(t) Not be involuntarily terminated or transferred from services without prior notice, notification of available sources of necessary continued services, and exercise of a complaint procedure;

(u) Advance written notice of any action that terminates, suspends, reduces, or denies a service or request for service, notification of available sources of necessary continued services, and a hearing to challenge an action that terminates, suspends, reduces, or denies a service or request for service;

(v) Be informed at the start of services and annually thereafter of the rights guaranteed by this rule, the contact information for the protection and advocacy system described in ORS 192.517(1), and the procedures for filing complaints, reviews, hearings, or appeals if services have been or are proposed to be terminated, suspended, reduced, or denied;

(w) Be encouraged and assisted in exercising all legal, civil, and human rights;

(x) Exercise all rights set forth in ORS 426.385 and 427.031 if the individual is committed to the Department;

(y) Be informed of and have the opportunity to assert complaints as described in OAR 411-318-0015 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 complaint procedure without any form of retaliation or punishment;

(z) Freedom to exercise all rights described in this rule without any form of reprisal or punishment; and

(aa) 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 of the family member, if known, as provided under ORS 430.212 and OAR 411-320-0090.

(2) The individual rights described in section (1) of this rule apply to all individuals' eligible for or receiving a developmental disabilities service. A parent or guardian may place reasonable limitations on the rights of a child.

(3) In addition to the rights described in section (1) of this rule, individuals receiving home and community-based services in residential and non-residential home and community-based settings have the right to home and community-based settings with the qualities described in OAR 411-004-0020(1).

(4) In addition to the rights described in sections (1) of this rule, individuals receiving home and community-based services in provider owned, controlled, or operated residential settings have the right to provider owned, controlled, or operated residential settings with the qualities described in OAR 411-004-0020(2).

(a) For children under the age of 18, enrolled in or utilizing home and community-based services, and residing in provider owned, controlled, or operated residential settings, the qualities described in OAR 411-004-0020(2) apply in the context of addressing any limitations beyond what are typical health and safety precautions or discretions utilized for children of the same age without disabilities.

(b) Health and safety precautions or discretions utilized for children under the age of 18, enrolled in or utilizing home and community-based services, and residing in provider owned, controlled, or operated residential settings, must be addressed through a person-centered service planning process and documented in the ISP for the child.

(c) Limitations that deviate from and are more restrictive than what is typical for children of the same age without disabilities must comply with OAR 411-004-0040.

(5) The rights described in this rule are in addition to, and do not limit, all other statutory and constitutional rights that are afforded all citizens including, but not limited to, the right to exercise religious freedom, vote, marry, have or not have children, own and dispose of property, and enter into contracts and execute documents.

(6) The rights described in this rule may be asserted and exercised by an individual, the legal representative of an individual, and any representative designated by an individual.

(7) Nothing in this rule may be construed to alter any legal rights and responsibilities between a parent and child.

(8) A guardian is appointed for an adult only as is necessary to promote and protect the well-being of the adult. A guardianship for an adult must be designed to encourage the development of maximum self-reliance and independence of the adult, and may be ordered only to the extent necessitated by the actual mental and physical limitations of the adult. An adult for whom a guardian has been appointed is not presumed to be incompetent. An adult 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 an adult include, but are not limited to, the right to contact and retain counsel and to have access to personal records. (ORS 125.300).

Stat. Auth.: ORS 409.050, 427.107

Stats. Implemented: ORS 183.411-471, 409.010, 427.107, 427.109

Hist.: APD 22-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 40-2014, f. 12-26-14, cert. ef. 12-28-14; APD 37-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 17-2016, f. 6-28-16, cert. ef. 6-29-16

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Rule Caption: ODDS: In-Home Support for Children and Adults with Intellectual or Developmental Disabilities
Adm. Order No.: APD 18-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 4-1-2016
Rules Repealed: 411-308-0010, 411-308-0020, 411-308-0030, 411-308-0040, 411-308-0050, 411-308-0060, 411-308-0070, 411-308-0080, 411-308-0090, 411-308-0100, 411-308-0110, 411-308-0120, 411-308-0130, 411-308-0135, 411-308-0140, 411-308-0150, 411-330-0010, 411-330-0020, 411-330-0030, 411-330-0040, 411-330-0050, 411-330-0060, 411-330-0065, 411-330-0070, 411-330-0080, 411-330-0090, 411-330-0100, 411-330-0110, 411-330-0120, 411-330-0130, 411-330-0140, 411-330-0150, 411-330-0160, 411-330-0170
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently repealing the rules in:

- OAR chapter 411, division 308 for in-home support for children with intellectual or developmental disabilities; and
- OAR chapter 411, division 330 for comprehensive in-home support for adults with intellectual or developmental disabilities.

The Department is restructuring many of the rule divisions that relate to developmental disabilities services to provide more consistency, remove redundancies, and consolidate the requirements for services available through the Community First Choice state plan amendment and the 1915(c) waivers operated by the Department.

Due to the restructure, the Department will no longer need the rules in OAR chapter 411, divisions 308 and 330 because all of the rule language currently contained in OAR chapter 411, divisions 308 and 330 will be moved to the following rule divisions:

- OAR chapter 411, division 450 for community living supports will include the rule language for attendant care, relief care, and skills training.
- OAR chapter 411, division 435 for ancillary services will include the rule language for the services available through the Community First Choice state plan amendment and the 1915(c) waivers operated by the Department that do not fall within the purview of community living supports.
- OAR chapter 411, division 375 for independent providers will include the qualifications and standards for independent providers and employers.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

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Rule Caption: ODDS: CIIS — Behavior Program, Medically Fragile Children's Services, and Medically Involved Children's Program
Adm. Order No.: APD 19-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 5-1-2016
Rules Amended: 411-300-0100, 411-300-0110, 411-300-0120, 411-300-0150, 411-300-0190, 411-300-0205
Rules Repealed: 411-300-0130, 411-300-0155, 411-300-0165, 411-300-0170, 411-300-0175, 411-300-0200, 411-350-0010, 411-350-0020, 411-350-0030, 411-350-0040, 411-350-0050, 411-350-0075, 411-350-0080, 411-350-0085, 411-350-0100, 411-350-0110, 411-350-0115, 411-355-0000, 411-355-0010, 411-355-0020, 411-355-0030, 411-355-0040, 411-355-0045, 411-355-0050, 411-355-0075, 411-355-0080, 411-355-0090, 411-355-0100
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the rules for children's intensive in-home services (CIIS) in OAR chapter 411, division 300 to make permanent the temporary rule changes that became effective on January 1, 2016.

In addition, the Department is restructuring the CIIS rules to ensure uniform standards, provide more consistency, consolidate requirements, remove redundancies, and reduce the need for multiple rule changes in the future. Specifically, the Department is:

- Addressing the three CIIS programs (Behavior Program, Medically Fragile Children's Services (MFC), and Medically Involved

Children's Program (MICP)) in one rule and repeal the rules in OAR chapter 411, division 350 and 355;

- Removing:

- Terms included in the general definitions rule, OAR 411-317-0000;

- The requirements now found in OAR chapter 411, division 415 related to the delivery of case management services and other service access activities, including related requirements for CIIS services coordinators;

- Standards for employers and independent providers, including personal support workers now found in OAR chapter 411, division 375; and

- Community First Choice (K Plan) and waiver service descriptions as they are now included in OAR chapter 411, division 435 (Ancillary Services) and OAR chapter 411, division 450 (Community Living Supports);

- Incorporating the adoption of the rules for home and community-based (HCB) services and settings and person-centered service planning in OAR chapter 411, division 004 to implement the regulations and expectations of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS); and

- Moving the content related to private duty nursing and clarify the eligibility criteria for private duty nursing services authorized and administered by the MFC Program for children and young adults residing in the family home or a foster home.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-300-0100
Statement of Purpose

(1) The rules in OAR chapter 411, division 300 prescribe standards, responsibilities, and procedures for the Department to partner with families and community partners in the delivery of specialized in-home services through a combination of Community First Choice state plan services and one of three Children's Intensive In-Home Services (CIIS) Programs.

(2) CIIS programs are comprised of three 1915(c) Home and Community-Based Services (HCBS) Model Waivers:

(a) Behavioral Model Waiver services are exclusively intended for a child with an intellectual or developmental disability with significant behaviors as indicated by the Behavior Criteria who require an ICF/ID level of care.

(b) Medically Fragile Model Waiver services are exclusively intended for a child with significant medical needs as indicated by the Medically Fragile Clinical Criteria who require a hospital level of care.

(c) Medically Involved Model Waiver services are exclusively intended for a child with significant medical needs as indicated by the Medically Involved Children's Waiver Criteria who require a nursing facility level of care.

(3) The goals of CIIS are to:

(a) Provide appropriate supports and services to ensure health and safety in the family home;

(b) Maximize independence and increase the ability to engage in a life that is fully integrated into the community; and

(c) Prevent out-of-home placement of the child.

(4) CIIS complement and supplement the services that are available through the State Medicaid Plan and other federal, state, and local programs as well as the natural supports that families and communities provide.

(5) CIIS are delivered in a setting that is in compliance with OAR 411-004-0020(1).

Stat. Auth.: ORS 409.050, 417.345
Stats. Implemented: ORS 417.345, 427.005, 427.007, 430.215
Hist.: SDSD 12-2002, f. 12-26-02, cert. ef. 12-28-02; SPD 13-2004, f. & cert. ef. 6-1-04; SPD 11-2009, f. 7-31-09, cert. ef. 8-1-09; SPD 53-2013, f. 12-27-13. cert. ef. 12-28-13; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 19-2016, f. 6-28-16, cert. ef. 6-29-16

411-300-0110
Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 300:

(1) "ADL" means "activities of daily living".

(2) "Alternative Resources" mean possible resources available for the provision of supports to meet the needs of a child. Alternative resources include, but are not limited to, private or public insurance, vocational rehabilitation services, supports available through the Oregon Department of Education, or other community supports.

(3) "Behavior Criteria" means the criteria used by the Department to evaluate the intensity of the behaviors, challenges, and service needs of a child and to determine eligibility for the ICF/ID Behavioral Model Waiver.

(4) "CDDP" means "Community Developmental Disabilities Program".

(5) "Child" means an individual who is less than 18 years of age, and applying for, or accepted for, CIIS.

(6) "CIIS" means "Children's Intensive In-home Services". CIIS includes case management from a Department-employed services coordinator and the services authorized by the Department delivered through:

(a) The ICF/ID Behavioral Program;

(b) The Medically Fragile Children's Program; and

(c) The Medically Involved Children's Program.

(7) "Clinical Criteria" means the Clinical Criteria used by the Department to assess a child's initial and ongoing eligibility for the Medically Fragile Children's Program and the support needs of a child annually, or as needed, to determine the overall assessed needs of the child. The Clinical Criteria incorporates documentation of the requirement for "Assist" or "Full Assist" in activities outlined in OAR 411-015-0010.

(8) "Cost Effective" means being responsible and accountable with Department resources by offering less costly alternatives when providing choices that adequately meet the support needs of a child. Less costly alternatives include other programs available from the Department and the utilization of assistive devices, natural supports, environmental modifications, and alternative resources. Less costly alternatives may include resources not paid for by the Department.

(9) "Daily Activity Log" means the record of services provided by a paid care provider to a child. The content and form of a daily activity log is agreed upon by both the parent or guardian and the services coordinator and documented in the ISP for the child.

(10) "Delegation" is the process where a registered nurse authorizes an unlicensed person to perform nursing tasks and confirms that authorization in writing. Delegation may occur only after a registered nurse follows all steps of the delegation process as outlined in OAR chapter 851, division 047.

(11) "Entry" means admission to a Department-funded service.

(12) "Exit" means termination or discontinuance of enrollment in CIIS.

(13) "Expenditure Guidelines" mean the guidelines published by the Department that describe allowable uses for Department funds. The Department incorporates the Expenditure Guidelines into these rules by this reference. The Expenditure Guidelines are maintained by the Department at: http://www.oregon.gov/dhs/dd/. Printed copies may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(14) "Family":

(a) Means a unit of two or more people that includes at least one child who is eligible for CIIS 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, such as child-rearing, maintenance of the residence, and basic living expenses; and

(iii) Joint responsibility for supporting a child when the child 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 the eligibility of a child for enrollment into CIIS as a resident in the family home;

(B) Identifying people who may apply, plan, and arrange for individual services; and

(C) Determining who may receive family training.

(15) "Family Home" means the primary residence for a child that is not under contract with the Department to provide services as a certified foster home or a licensed or certified residential care facility, assisted living facility, nursing facility, or other residential setting.

(16) "ICF/ID Behavioral Model Waiver" means the 1915(c) Home and Community-Based Services waiver granted by the federal Centers for Medicare and Medicaid Services that allows Medicaid funds to be spent on a child living in the family home who otherwise would have to be served in an intermediate care facility for individuals with intellectual or developmental disabilities if the waiver was not available.

(17) "ISP" means "Individual Support Plan".

(18) Medically Fragile Model Waiver" means the 1915(c) Home and Community-Based Services waiver 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 a hospital if the waiver was not available.

(19) "Medically Involved Criteria" means the criteria used by the Department to evaluate the intensity of the physical and medical challenges of a child and to determine eligibility for MICW services.

(20) "MFC" means "Medically Fragile Children". Medically fragile children have a health impairment that requires, intensive, specialized services on a daily basis, who have been found eligible for MFC services by the Department.

(21) "MICW" means "Medically Involved Children's Waiver". MICW is the waiver granted by the federal Centers for Medicare and Medicaid Services that allows Medicaid funds to be spent on a child living in the family home who otherwise would have to be served in a nursing facility if the waiver program was not available.

(22) "OHP" means the Oregon Health Plan.

(23) "Parent" means the biological parent, adoptive parent, or stepparent of a child. Unless otherwise specified, references to parent also include a person chosen by the parent or guardian to serve as the designated representative of the parent or guardian in connection with the provision of Department funded supports.

(24) "Primary Caregiver" means the parent, guardian, relative, or other non-paid parental figure of a child that normally provides direct care to the child. In this context, the term parent or guardian may include a designated representative.

(25) "Private Duty Nursing" means the nursing services described in OAR 411-300-0150 that are determined medically necessary to support a child or young adult receiving MFC services in the family home.

(26) "Support" means the assistance that a child and a family requires, solely because of the effects of the qualifying disability of the child, to maintain or increase the age-appropriate independence of the child, achieve age-appropriate community presence and participation of the child, and to maintain the child in the family home. Support is subject to change with time and circumstances.

(27) "These Rules" mean the rules in OAR chapter 411, division 300.

(28) "Young Adult" means an individual aged 18 through 20.

Stat. Auth.: ORS 409.050, 417.345

Stats. Implemented: ORS 417.345, 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; SPD 53-2013, f. 12-27-13. cert. ef. 12-28-13; APD 31-2014(Temp), f. & cert. ef. 8-20-14 thru 2-16-15; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 40-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 19-2016, f. 6-28-16, cert. ef. 6-29-16

411-300-0120
Eligibility for CIIS

(1) ASSESSMENT. An assessment of a child for a determination of eligibility for entry into CIIS, may be requested by a services coordinator, or the legal guardian.

(2) GENERAL ELIGIBILITY. In order to be eligible for CIIS, a child must:

(a) Be under the age of 18 or under 21 for young adults who meet the requirements of section (5) of this rule and are accessing Private Duty Nursing services only.

(b) Be an Oregon resident who meets the citizenship and alien status requirements of OAR 461-120-0110.

(c) Be receiving Medicaid Title XIX benefits under OSIPM. A child receiving CHIP Title XXI benefits is not eligible to receive supports and services through CIIS.

(d) For a child with excess income, contribute to the cost of services pursuant to OAR 461-160-0610 and 461-160-0620.

(e) Reside in the family home (except for children or young adults living in foster care who are eligible for private duty nursing services only).

(f) Be safely served in the family home. This includes, but is not limited to, a qualified primary caregiver demonstrating the willingness, skills, and ability to provide direct care as outlined in an ISP in a cost effective manner, as determined by a services coordinator, and participate in planning, monitoring, and evaluation of the services provided.

(3) ELIGIBILITY FOR ICF/ID BEHAVIOR PROGRAM. In addition to the requirements listed in section (2) of this rule, a child must:

(a) Be determined eligible for developmental disability services by the CDDP of the county of origin as described in OAR 411-320-0080;

(b) Meet the ICF/IDD level of care as defined in OAR 411-317-0000; and

(c) Be accepted by the Department by scoring 200 or greater on the Behavior Conditions Criteria within two months prior to starting services and maintain a score of 200 or greater as determined by reassessment annually.

(4) ELIGIBILITY FOR MEDICALLY FRAGILE CHILDREN'S WAIVER. In addition to the requirements listed in section (2) of this rule, a child must:

(a) Meet the hospital level of care defined in OAR 411-317-0000.

(b) Be accepted by the Department by scoring 45 or greater on the MFC Clinical Criteria prior to starting services and have a status of medical need that is likely to last for more than two months and maintain a score of 45 or greater on the MFC Clinical Criteria as assessed every six months.

(5) ELIGIBILITY FOR INDIVIDUALS TO RECEIVE PRIVATE DUTY NURSING SERVICES THROUGH THE MEDICALLY FRAGILE CHILDREN'S PROGRAM. A child or young adult who is not enrolled on the MFC Waiver and who resides in a foster home or their family home may be eligible for private duty nursing when the requirements listed in section (2) of this rule are met, and the individual:

(a) Is accepted by the Department by scoring 45 or greater on the MFC Clinical Criteria prior to starting services and have a status of medical need that is likely to last for more than two months and maintain a score of 45 or greater on the MFC Clinical Criteria as assessed every six months.

(b) Resides in a foster home is eligible for private duty nursing only as described in OAR 411-300-0150;

(c) Meets the requirements to receive Private Duty Nursing only as described in OAR 411-300-0150 when a young adult resides in the family home.

(6) ELIGIBILITY FOR MEDICALLY INVOLVED CHILDREN'S WAIVER. In addition to the requirements listed in section (2) of this rule, a child must:

(a) Meet the nursing facility level of care as defined in OAR 411-317-0000;

(b) Be accepted by the Department by scoring 100 or greater on the MICW Criteria and maintain an eligibility score of 100 or greater as determined by reassessment annually; and

(c) Require services offered under the Medically Involved Children's Waiver.

(7) EXIT. A child may be exited from CIIS in any of the following circumstances:

(a) The child is exited from case management services as described in OAR 411-415-0030.

(b) The child no longer meets the general eligibility criteria in section (2) of this rule.

(c) The child or no longer meets the eligibility requirements for:

(A) The ICF/ID Behavioral Program described in section (3) of this rule;

(B) The Medically Fragile Children's Program described in section (4) of this rule; and

(C) The Medically Involved Children's Program described in section (5) of this rule.

(d) A young adult no longer meets criteria for Private Duty Nursing Services as described in OAR 411-300-0150.

(e) The Department has sufficient evidence the parent or guardian has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP, refused to cooperate with documenting expenses of Department funds, or otherwise knowingly misused public funds associated with CIIS.

(f) The child is incarcerated or admitted to a medical hospital, psychiatric hospital, sub-acute facility, nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities, foster home, or other 24-hour residential setting and it is determined that the child is not returning to the family home or is not returning to the family home after 90 consecutive days.

(g) At the oral or written request of a parent or guardian to end the service relationship and documented in the file of the child.

(h) The child may not be safely served in the family home as described in section (2)(f) of this rule.

(i) The parent, guardian and child either cannot be located or has not responded after 30 days of repeated attempts by a services coordinator to complete ISP development or monitoring activities including participation in a functional needs assessment.

(j) The child does not reside in Oregon.

(8) TRANSITION DUE TO INELIGIBILITY FOR CIIS.

(a) A child who no longer meets eligibility criteria must be transitioned from CIIS no later than 30 days from the date of the assessment that determined ineligibility for the program.

(b) The CIIS program shall assist families to identify alternate resources.

(c) In the event a CIIS model waiver program enrollment is ended, a written Notification of Planned Action must be provided as described in OAR chapter 411, division 318.

(9) WAIT LIST. If the maximum number of children allowed on the approved Model Waiver are enrolled and being served in the program, the Department may place a child eligible for CIIS on a wait list. A child on the wait list may access other Medicaid or General Fund services for which the child is determined eligible.

(a) The date the Department has received the initial completed application for CIIS determines the order on the wait list.

(b) A child who was previously enrolled in CIIS and currently meets the criteria for eligibility as described in section (2) of this rule, is put on the wait list as of the date the original application for CIIS was complete.

(c) The date the application for CIIS is complete is the date that the Department has received the complete referral.

(d) Children on the wait list are served on a first come, first served basis as space in CIIS allows. A reassessment is completed prior to entry to determine current eligibility. A child must be:

(A) Reassessed for the behavior model waiver if the current assessment is more than 60 days old.

(B) Reassessed for the Medically Involved Waiver if the current assessment is more than 120 days old.

(C) Newly assessed for the Medically Fragile waiver.

(e) A child on the wait list is prioritized for entry into the Medically Involved Children's Waiver if the child is currently residing in a nursing facility for long term care and the family of the child wishes the child to return home, or the child resides in the community and is at imminent risk of placement in a nursing facility. An evaluation is completed prior to entry to determine current eligibility.

Stat. Auth.: ORS 409.050, 417.345

Stats. Implemented: ORS 417.345, 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; SPD 53-2013, f. 12-27-13. cert. ef. 12-28-13; APD 31-2014(Temp), f. & cert. ef. 8-20-14 thru 2-16-15; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 8-2015, f. & cert. ef. 3-12-15; APD 10-2015(Temp), f. 4-2-15, cert. ef. 4-10-15 thru 10-6-15; APD 20-2015, f. 10-5-15, cert. ef. 10-6-15; APD 19-2016, f. 6-28-16, cert. ef. 6-29-16

411-300-0150

Scope of CIIS and Limitations

(1) Services available through CIIS are intended to support, not supplant, the naturally occurring services provided by a legally responsible primary caregiver and enable the primary caregiver to meet the needs of caring for a child in CIIS. CIIS services are not meant to replace other available governmental or community services and supports. All services funded by the Department must be provided in accordance with the Expenditure Guidelines and based on the actual and customary costs related to best practice standards of care for children with similar disabilities.

(2) A services coordinator is required to provide case management and other supports described in OAR chapter 411, division 415.

(3) To be authorized and eligible for payment by the Department, all CIIS services and supports must be:

(a) Directly related to the disability of the child or young adult;

(b) Required to maintain health and safety of a child;

(c) Cost effective;

(d) Considered not typical for a parent or guardian to provide to a child of the same age;

(e) Required to help the parent or guardian to continue to meet the needs of caring for the child;

(f) Included in an approved ISP;

(g) Provided in accordance with the Expenditure Guidelines; and

(h) Based on the actual and customary costs related to best practice standards of care for children with similar disabilities.

(4) Department funds may be used to purchase a combination of the following:

(a) Ancillary services as described in OAR chapter 411, division 435;

(b) Community living supports as described in OAR chapter 411, division 450;

(c) CIIS services as described in these rules;

(d) State Plan personal care services as described in OAR chapter 411, division 034; and

(e) Private duty nursing as described in OAR chapter 410, division 132.

(5) BEHAVIOR SUPPORT SERVICES. Positive Behavioral Support Services are provided to assist individuals with behavioral challenges due to their disability, that prevent them from accomplishing ADL's, IADL's, and health related tasks. Positive Behavior Support Services include coaching and support of positive behaviors, behavior modification and intervention supports to allow individuals to develop, maintain or enhance skills to accomplish ADL's, IADLs and health related tasks. The need for these services is determined through a functional needs assessment and the individual's goals as identified in the person centered planning process. Positive Behavioral Support Services may also include consultation to the care provider on how to mitigate behavior that may place the individual's health and safety at risk and prevent institutionalization. Services may be implemented in the home or community, based on an individual's assessed needs. All activities must be for the direct benefit of the Medicaid beneficiary.

(a) A qualified behavior consultant must:

(A) Work with the child, primary caregiver, and if applicable, caregivers to:

(i) Address the needs of the person to acquire, maintain and enhance skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living and health related tasks.

(ii) Areas of the family home life that are of most concern for the child and the parent or guardian;

(iii) The formal or informal responses the family or the provider has used in those areas; and

(iv) The unique characteristics of the child and family that may influence the responses that may work with the child.

(B) Assess the child. 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 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; and

(vi) An assessment of current communication strategies.

(C) Develop a variety of positive strategies that assist the primary caregiver and the provider to help the child use acceptable, alternative actions to assist the individual to develop or enhance skills to accomplish ADL/IADL and health related tasks in the safest, most positive, and cost effective manner. These strategies may include changes in the physical and social environment, developing effective communication, and appropriate responses by the primary caregiver.

(i) When interventions in behavior are necessary, the interventions must be performed in accordance with positive behavioral theory and practice as defined in OAR 411-317-0000.

(ii) The least intrusive intervention possible to keep the child and others safe 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) Develop a written Behavior Support Plan using clear, concrete language that is understandable to the individual, primary caregiver and the provider that describes the assessment, strategies, and procedures to be used.

(E) Develop emergency and crisis procedures to be used to keep the child, primary caregiver, and the 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 use of protective physical intervention must be part of the Behavior Support Plan for the child. When protective physical intervention is required, the protective physical intervention must only be used as a last resort and the provider must be appropriately trained in OIS.

(F) Teach the primary caregiver and the provider the strategies and procedures to be used.

(G) Monitor and revise the Behavior Support Plan as needed.

(b) Behavior support services may include:

(A) Training a primary caregiver or provider of a child on the behavior modifications and interventions identified in the BSP;

(B) Developing a visual communication system as a strategy for behavior support; and

(C) Communicating, as authorized by a parent or guardian through a release of information, with other professionals about the strategies and outcomes of the Behavior Support Plan as written in the Behavior Support Plan within authorized consultation hours only.

(c) Behavior support services exclude:

(A) Rehabilitation or treatment of mental health conditions, including but not limited to 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 the needs of a child at school;

(E) An assessment in a school setting;

(F) Attendant care;

(G) Relief care; or

(H) Communication or activities not directly related to the development, implementation, or revision of the Behavior Support Plan.

(6) PRIVATE DUTY NURSING. If the service needs of a child or young adult enrolled in the Medically Fragile Children's Program require the presence of an RN or LPN on an ongoing basis as determined medically necessary based on the clinical criteria and the functional needs assessment of the child or young adult, private duty nursing services may be allocated to ensure medically necessary supports are provided.

(a) Private duty nursing may be provided on a shift staffing basis as necessary.

(b) Private duty nursing must be delivered by a licensed RN or LPN, who does not have limitations of service provision as defined in OAR 410-132-0080, as determined by the service needs of the child or young adult and documented in the ISP and Nursing Service Plan.

(c) The amount of private duty nursing available to a child or young adult is based on the acuity level of the child or young adult as measured by the MFC Clinical Criteria as follows:

(A) Level 1. Score of 75 or above and on a ventilator for 20 hours or more per day = up to a maximum of 554 nursing hours per month;

(B) Level 2. Score of 70 or above = up to a maximum of 462 nursing hours per month;

(C) Level 3. Score of 65 to 69 = up to a maximum of 385 nursing hours per month;

(D) Level 4. Score of 60 to 64 = up to a maximum of 339 nursing hours per month;

(E) Level 5. Score of 50 to 59 or if a child requires ventilation for sleeping hours = up to a maximum of 293 nursing hours per month; and

(F) Level 6. Score of 45 to 49 = up to a maximum of 140 nursing hours per month.

(7) All requests for expenditures exceeding limitations in the Expenditure Guidelines must be authorized by the Department. The approval of the Department is limited to 90 days unless re-authorized. A request for a General Fund expenditure or an expenditure exceeding limitations in the Expenditure Guidelines is only authorized in the following circumstances:

(a) The child is not safely served in the family home without the expenditure;

(b) The expenditure provides supports for the emerging or changing service needs or behaviors of the child;

(c) A significant medical condition or event, as documented by a primary care provider, prevents or seriously impedes the primary caregiver from providing services; or

(d) The program determines, with a behavior consultant or medical professional, that the 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 a caregiver, including the parent or guardian, has been trained in behavior or medical management and that all other feasible recommendations from the behavior consultant or medical professional and the services coordinator have been implemented.

Stat. Auth.: ORS 409.050, 417.345

Stats. Implemented: ORS 417.345, 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; SPD 53-2013, f. 12-27-13. cert. ef. 12-28-13; APD 31-2014(Temp), f. & cert. ef. 8-20-14 thru 2-16-15; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 40-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 19-2016, f. 6-28-16, cert. ef. 6-29-16

411-300-0190

CIIS Documentation Needs

(1) Documentation of services provided, including but not limited to daily activity logs as prescribed by the services coordinator, must be provided to the services coordinator upon request or as outlined in the ISP and maintained in the family home or the place of business of the provider of services. The Department does not pay for services that are not outlined in the ISP.

(2) Daily activity logs must be completed by the provider for each shift worked and the responsibility to complete daily activity logs must be listed in the service agreement for the provider.

(3) Providers must maintain documentation of provided services for at least seven years from the date of service. If a provider is a nurse, the nurse must either maintain documentation of provided services for at least five years or send the documentation to the Department.

(4) Providers must furnish requested documentation immediately upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, Centers for Medicare and Medicaid Services, or their authorized representatives, and within the time frame specified in the written request. Failure to comply with the request may be considered by the Department as reason to deny or recover payments.

(5) Access to records by the Department, including but not limited to medical, nursing, behavior, psychiatric, or financial records, and specifically including daily activity logs and records by providers and vendors providing goods and services, does not require an authorization for release of information by the child as applicable, or the parent or guardian of the child.

(6) CIIS services coordinators must comply with documentation requirements as described in OAR 411-415-0110.

Stat. Auth.: ORS 409.050, 417.345

Stats. Implemented: ORS 417.345, 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 53-2013, f. 12-27-13. cert. ef. 12-28-13; APD 31-2014(Temp), f. & cert. ef. 8-20-14 thru 2-16-15; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 19-2016, f. 6-28-16, cert. ef. 6-29-16

411-300-0205

Rights, Complaints, Notification of Planned Action, and Hearings

(1) INDIVIDUAL RIGHTS.

(a) The rights of a child are described in OAR 411-318-0010.

(b) Upon entry and request and annually thereafter, the individual rights described in OAR 411-318-0010 must be provided to the child as applicable, and parent or guardian of the child.

(2) COMPLAINTS.

(a) Complaints must be addressed in accordance with OAR 411-318-0015.

(b) Upon entry and request and annually thereafter, the policy and procedures for complaints as described in OAR 411-318-0015 must be explained and provided to the child as applicable, and the parent or guardian of the child.

(3) NOTIFICATION OF PLANNED ACTION. In the event services are denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form APD 0947) must be provided as described in OAR 411-318-0020.

(4) HEARINGS.

(a) Hearings must be addressed in accordance with ORS Chapter 183 and OAR 411-318-0025.

(b) A parent or guardian may request a hearing as provided in ORS Chapter 183 and OAR 411-318-0025.

(c) Upon entry and request and annually thereafter, a notice of hearing rights and the policy and procedures for hearings as described in OAR chapter 411, division 318 must be explained and provided to the child as applicable, and the parent or guardian of the child.

Stat. Auth.: ORS 409.050, 417.345

Stats. Implemented: ORS 417.345, 427.005, 427.007, 430.215

Hist.: SPD 11-2009, f. 7-31-09, cert. ef. 8-1-09; SPD 53-2013, f. 12-27-13. cert. ef. 12-28-13; APD 31-2014(Temp), f. & cert. ef. 8-20-14 thru 2-16-15; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 19-2016, f. 6-28-16, cert. ef. 6-29-16

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Rule Caption: ODDS: Ancillary Services for Individuals Receiving Office of Developmental Disabilities Services
Adm. Order No.: APD 20-2016
Filed with Sec. of State: 6-29-2016
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Rules Adopted: 411-435-0010, 411-435-0020, 411-435-0030, 411-435-0040, 411-435-0050, 411-435-0060, 411-435-0070, 411-435-0080

Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is adopting rules for ancillary services in OAR chapter 411, division 435 to include eligibility requirements, service descriptions, service limits, and provider qualifications for certain services available under the 1915(k) and 1915(c) funding authorities. These rules are drawn from portions of existing, almost identical, rules in OAR chapter 411 divisions 300, 308, 330, 340, 350, and 355. The relevant portions of those rules are being repealed and put into this new division. Adopting OAR chapter 411, division 435 will assure that variations in the present rules are eliminated.

The Department is also incorporating new sections into OAR chapter 411, division 435 that were not in prior rules, including:

- Department-wide financial eligibility requirements for long-term services as described in OAR 461-145-0220.

- A requirement that an individual must receive three bids before making an environmental modification or environmental safety modification.

- Clarify the policy requiring that purchases made to meet a single identified goal on an ISP must be considered together as one cost for the purpose of triggering a review by the Department prior to the purchase.

- Prohibiting, in most circumstances, providers who may have an advantage in being selected due to their relationship with the individual from providing services to the individual with which the relationship exists.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-435-0010
Statement of Purpose

(1) These rules ensure individuals receiving services provided by the Department of Human Services, Office of Developmental Disabilities Services through the Community First Choice State Plan Amendment and 1915(c) waivers are able to maximize independence, empowerment, dignity, and human potential through the provision of flexible, efficient, and suitable services.

(2) These rules ensure equal access to individuals who are eligible for the ancillary services provided through these rules.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 20-2016, f. & cert. ef. 6-29-16

411-435-0020
Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 435:

(1) "ADL" means "Activities of Daily Living".

(2) "Ancillary Services" mean the array of services described in these rules that may be authorized as stand-alone services, separate from attendant care, relief care, and skills training, and an all-inclusive rate paid to a residential program or a foster care provider.

(3) "Assistive Devices" mean the ancillary service that makes available devices, aids, controls, supplies, or appliances necessary to enable an individual to increase the ability of the individual to perform ADL and IADLs or to communicate in the home and community. Assistive devices are available through the Community First Choice State Plan Amendment.

(4) "Assistive Technology" means the ancillary service that makes available devices, aids, controls, supplies, or appliances that are purchased to provide support for an individual and replace the need for direct interventions or to increase independence. Assistive technology is available through the Community First Choice State Plan Amendment.

(5) "CDDP" means "Community Developmental Disabilities Program".

(6) "Chore Services" mean the ancillary services that are needed to restore a hazardous or unsanitary situation in the home of an individual to a sanitary, safe environment. Chore services are available through the Community First Choice State Plan Amendment.

(7) "CIIS" means "Children's Intensive In-home Services". CIIS include the services authorized by the Department delivered through:

(a) The ICF/ID Behavioral Program;

(b) The Medically Fragile Children's Program; and

(c) The Medically Involved Children's Waiver.

(8) "Community Nursing Services" means the ancillary service that provides for the nursing services that focus on the chronic and ongoing health and safety needs of an individual. Community nursing services are provided according to the rules in OAR chapter 411, division 048 and the Oregon State Board of Nursing rules in OAR chapter 851. Community nursing services are available through the Community First Choice State Plan Amendment.

(9) "Environmental Modifications" mean the ancillary service that provides for physical adaptations that are necessary to ensure the health, welfare, and safety of an individual in his or her own home, or that are necessary to enable the individual to function with greater independence around his or her own home or lead to a substitution for, or decrease in, direct human assistance to the extent expenditures may otherwise be made for human assistance. Environmental modifications are available through the Community First Choice State Plan Amendment.

(10) "Environmental Safety Modifications" mean the ancillary service that provides for physical adaptations that are made to the exterior of the home of an individual or the home of the family of the individual as identified in the ISP for the individual to ensure the health, welfare, and safety of the individual or to enable the individual to function with greater independence around the home or lead to a substitution for, or decrease in, direct human assistance to the extent expenditures may otherwise be made for human assistance. Environmental safety modifications are available through a 1915(c) waiver.

(11) "Family Training" means the ancillary service that provides for the training services that are available to the family of an individual to increase the capacity of the family to care for, support, and maintain the individual in the home of the individual. Family training is available through a 1915(c) waiver.

(12) "IADL" means "Instrumental Activities of Daily Living".

(13) "Individual-Directed Goods and Services" means the ancillary service that provides for services, equipment, or supplies not otherwise provided through other waiver or state plan services, that address an identified need in an ISP. Individual-directed goods and services may include services, equipment, or supplies that maintain a child in the community. Individual-directed goods and services are available through a 1915(c) waiver.

(14) "In-Home Expenditure Guidelines" mean the guidelines published by the Department that describe allowable uses for Department funds. Effective January 1, 2015, the Department incorporates Version 2.0 of the In-home Expenditure Guidelines into these rules by this reference. The In-home Expenditure Guidelines are maintained by the Department at: http://www.oregon.gov/dhs/dd/adults/ss_exp_guide.pdf. A printed copy may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(15) "ISP" means "Individual Support Plan".

(16) "OCCS" means the "Oregon Health Authority, Office of Client and Community Services".

(17) "OHP" means "Oregon Health Plan".

(18) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(19) "Scope of Work" means the written statement of all proposed work requirements for an environmental modification which may include dimensions, measurements, materials, labor, any pertinent building permits, and outcomes necessary for a contractor to submit a proposal to complete such work. The scope of work is specific to the identified tasks and requirements necessary to address the needs outlined in the supplemental assessment referenced in the ISP and relating to the ADL, IADL, and health-related tasks of the individual as discussed by the individual, designated representative, legal representative, homeowner, case manager, and ISP team.

(20) "Special Diets" means the ancillary service that provides for the specially prepared food or particular types of food that are specific to the medical condition or diagnosis of an individual and in support of an evidence-based treatment regimen.

(21) "Specialized Medical Supplies" mean the ancillary service, available through a 1915(c) waiver, that provides for medical and ancillary supplies such as:

(a) Necessary medical supplies specified in an ISP that are not available through state plan or alternative resources;

(b) Ancillary supplies necessary to the proper functioning of items necessary for life support or to address physical conditions; and

(c) Supplies necessary for the continued operation of augmentative communication devices or systems.

(22) "These Rules" mean the rules in OAR chapter 411, division 435.

(23) "Transition Costs" means the ancillary service that provides for 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 residing in a nursing facility or intermediate care facility for individuals with intellectual or developmental disabilities to residing in a community-based home. Transition costs are available through the Community First Choice State Plan Amendment.

(24) "Vehicle Modifications" means the ancillary service that provides for the adaptations or alterations that are made to the vehicle that is the primary means of transportation for an individual in order to accommodate the service needs of the individual. Vehicle modifications are available through a 1915(c) waiver.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 20-2016, f. & cert. ef. 6-29-16

411-435-0030
General Eligibility for Ancillary Services

(1) To be eligible for ancillary services an individual must:

(a) Be an Oregon resident.

(b) Be enrolled at a CDDP, a Brokerage, or a CIIS program.

(c) Be receiving Medicaid Title XIX (OHP) benefit package through OSIPM or OCCS medical program. Individuals receiving Medicaid OHP under OCCS medical coverage for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(A) The transfer of assets as set forth in OAR 461-140-0210 to 461-140-0300; and

(B) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(d) Be determined to meet the level of care as defined in OAR 411-415-0020.

(e) Demonstrate a need for the ancillary service.

(f) POST ELIGIBILITY TREATMENT OF INCOME. For individuals with excess income, contribute to the cost of service pursuant to OAR 461-160-0610 and 461-160-0620.

(g) For services available through the Community First Choice State Plan Amendment, participate in a functional needs assessment and provide information necessary to complete the functional needs assessments and reassessments within the time frame required by the Department.

(A) Failure to participate in the functional needs assessment or to provide information necessary to complete the functional needs assessment or reassessment within the applicable time frame results in the denial of service eligibility. In the event service eligibility is denied, a written Notification of Planned Action must be provided as described in OAR chapter 411, division 318.

(B) The Department may allow additional time if circumstances beyond the control of the individual or legal representative prevent timely participation in the functional needs assessment or timely submission of information necessary to complete the functional needs assessment or reassessment.

(h) A child receiving direct assistance funds under family support as described in OAR 411-305-0120 is not eligible to receive ancillary services.

(2) Additional service limits are described in these rules.

(3) Individuals who meet the general eligibility criteria described in this rule may be eligible for services equivalent to the services described in these rules from a residential program when the individual is enrolled to one through the program's all-inclusive rate.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 20-2016, f. & cert. ef. 6-29-16

411-435-0040
Conditions of Purchase

(1) Ancillary services must be authorized in an ISP consistent with OAR 411-415-0070.

(2) All ancillary services purchased must be in accordance with the In-home Expenditure Guidelines.

(3) Department funds may not be used for:

(a) A reimbursement to an individual, or the legal or designated representative or family of the individual, for expenses related to ancillary services.

(b) An advance payment of funds to an individual, or the legal or designated representative or family of the individual, to obtain ancillary services.

(c) Services, materials, or activities that are illegal.

(d) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 407-045-0260.

(e) Materials or equipment that has been determined unsafe for the general public by recognized consumer safety agencies.

(f) The purchase of a vehicle.

(g) Health and medical costs that the general public normally must pay, including, but not limited to:

(A) Medications;

(B) Health insurance co-payments;

(C) Mental health evaluation and treatment;

(D) Dental treatments and appliances;

(E) Medical treatments;

(F) Dietary supplements; or

(G) Treatment supplies not related to nutrition, incontinence, or infection control.

(h) Ambulance services.

(i) Legal fees including, but not limited to, costs of representation in educational negotiations, establishing trusts, or creating guardianships.

(j) Vacation costs that are normally incurred by a person on vacation, regardless of disability, and are not strictly required by the need of the individual for personal assistance in all home and community-based settings.

(k) Services or supports that are not necessary or cost-effective.

(l) Services that do not meet the description of ancillary services as described these rules, or that do not meet the definition of social benefits as defined in OAR 411-317-0000.

(m) Services, activities, materials, or equipment that may be obtained by the individual through other available means, such as private or public insurance, philanthropic organizations, or other governmental or public services.

(n) Services or activities for which the legislative or executive branch of Oregon government has prohibited use of public funds.

(o) Any purchase that is not generally accepted by the relevant mainstream professional or academic community as an effective means to address an identified support need.

(p) Services, supplies, or supports that are illegal, experimental, or determined unsafe for the general public by recognized child or consumer safety agencies.

(q) Services provided in a nursing facility, correctional institution, or hospital.

(r) Services, activities, materials, or equipment that may be obtained by the individual or the individual's family through alternative resources or natural supports.

(s) Services when there is sufficient evidence to believe that an individual or legal representative, or a provider chosen by an individual, has engaged in fraud or misrepresentation, failed to use resources as agreed upon in an ISP, refused to accept or delegate record keeping required to document use of Department funds.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 20-2016, f. & cert. ef. 6-29-16

411-435-0050
Developmental Disabilities Community First Choice Ancillary Services

The ancillary services described in this rule are available through the Community First Choice state plan amendment.

(1) COMMUNITY NURSING SERVICES.

(a) In addition to the general eligibility criteria listed in OAR 411-435-0030, to access community nursing services an individual may not be enrolled in a 24 hour residential program under OAR chapter 411, division 325. An individual enrolled in a supported living program under OAR chapter 411, division 328 is eligible to access community nursing services when the cost of the service is not included in the rate paid to the provider.

(b) Community nursing services include:

(A) Nursing assessments, including medication reviews;

(B) Care coordination;

(C) Monitoring;

(D) Development of a Nursing Service Plan;

(E) Delegation and training of nursing tasks to a provider and primary caregiver;

(F) Teaching and education of the provider and primary caregiver and identifying supports that minimize health risks while promoting the autonomy of an individual and self-management of healthcare; and

(G) Collateral contact with a case manager regarding the community health status of an individual to assist in monitoring safety and well-being and to address needed changes to the ISP for the individual.

(c) Community nursing services exclude direct nursing services as described in OAR chapter 411, division 380 and private duty nursing described in OAR chapter 411, division 300.

(d) A Nursing Service Plan must be present when Department funds are used for community nursing services. A case manager must authorize the provision of community nursing services as identified in an ISP.

(e) After an initial nursing assessment, a nursing re-assessment must be completed every six months or sooner if a change in a medical condition requires an update to the Nursing Service Plan.

(2) ENVIRONMENTAL MODIFICATIONS.

(a) In addition to the general eligibility criteria stated in OAR 411-435-0030, an individual may access this service if:

(A) Environmental modification may be reasonably expected to reduce the need for human assistance or increase an individual's independence with meeting an identified support need related to the completion of an ADL, IADL, or health related task; and

(B) The individual is not enrolled in a residential program, unless the enrollment is in a supported living program described in OAR chapter 411, division 328 and the dwelling is not a provider owned, controlled, or operated setting.

(b) Environmental modifications include, but are not limited to:

(A) Installation of shatter-proof windows;

(B) Hardening of walls or doors;

(C) Specialized, hardened, waterproof, or padded flooring;

(D) An alarm system for doors or windows;

(E) Protective covering for smoke alarms, light fixtures, and appliances;

(F) Installation of ramps, grab-bars, and electric door openers;

(G) Adaptation of kitchen cabinets and sinks;

(H) Widening of doorways;

(I) Handrails;

(J) Modification of bathroom facilities;

(K) Individual room air conditioners for an individual whose temperature sensitivity issues create behaviors or medical conditions that put the individual or others at risk;

(L) Installation of non-skid surfaces;

(M) Overhead track systems to assist with lifting or transferring;

(N) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual; and

(O) Adaptations to control the home environment including lights and heat.

(c) Environmental modifications exclude:

(A) Adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, and central air conditioning, unless directly related to the assessed health and safety needs of the individual and identified in the ISP for the individual as the most cost effective solution;

(B) Adaptations that add to the total square footage of the home except for ramps that attach to the home for the purpose of entry or exit;

(C) Except for ramps, adaptations outside of the home; and

(D) General repair or maintenance and upkeep required for the home.

(d) Environmental modifications must be tied to supporting assessed ADL, IADL, and health-related tasks as identified in the needs assessment and ISP for an individual.

(e) Environmental modifications are limited to $5,000 per modification. A case manager must request approval for additional expenditures through the Department prior to authorization of the service in an ISP. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-effectiveness. In addition, separate environmental modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(f) Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the file for the contractor prior to payment.

(g) 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.

(h) Payment to the contractor is to be withheld until the work meets specifications.

(i) A scope of work must be completed for each identified environmental modification project. All contractors submitting bids must be given the same scope of work.

(j) For all environmental modifications, a case management entity must assure a minimum of three written bids from qualified providers as described in OAR 411-435-0080 are acquired. When it is not possible to reasonably obtain three written bids, exceptions to this requirement may be granted by the Department.

(k) A case manager must assure the processes outlined in the In-home Expenditure Guidelines for contractor bids and the awarding of work are followed.

(l) All dwellings must be in good repair and have the appearance of sound structure.

(m) The identified home may not be in foreclosure or be the subject of legal proceedings regarding ownership.

(n) Environmental modifications must only be completed to the primary residence of the individual.

(o) Upgrades in materials that are not directly related to the health and safety needs of the individual are not paid for or permitted.

(p) Environmental modifications are subject to Department requirements regarding material and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials, manuals, and industry and risk management publications.

(q) RENTAL PROPERTY.

(A) Environmental modifications to rental property may not substitute or duplicate services otherwise the responsibility of the landlord under the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.

(B) Environmental modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.

(C) The Department does not fund work to restore the rental structure to the former condition of the rental structure.

(3) ASSISTIVE DEVICES. Assistive devices are primarily and customarily used to meet an ADL, IADL, or health-related support need. The purchase, rental, or repair of an assistive device with Department funds must be limited to the types of equipment and accessories that are not excluded under OAR 410-122-0080. An individual who meets the general eligibility criteria in OAR 411-435-0030 may access this service when assistive devices may be reasonably expected to reduce the need for human assistance, or increase an individual's independence, with meeting an identified support need related to the completion of an ADL, IADL, or health related task.

(a) Assistive devices may include the purchase of devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the ability of the individual to perform and support ADLs and IADLs or to communicate in the home and community.

(b) Assistive devices may be purchased with Department funds when the intellectual or developmental disability of an individual otherwise prevents or limits the independence of the individual in areas identified in a functional needs assessment.

(c) Assistive devices that may be purchased for the purpose described in subsection (b) of this section must be of direct benefit to the individual.

(d) Expenditures for assistive devices are limited to $5,000 per plan year without Department approval. Any single purchase costing more than $500 or any combination of items that meet a single assessed need totaling more than $500, must be approved by the Department prior to expenditure. A case manager must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and a determination by the Department of appropriateness and cost-effectiveness.

(e) Devices must be limited to the least costly option necessary to meet the assessed need of an individual.

(f) Assistive devices must meet applicable standards of manufacture, design, and installation.

(g) Assistive devices exclude:

(A) Items that do not address the underlying need for the device;

(B) Items intended to supplant similar items furnished under OHP, private insurance, or alternative resources;

(C) Items that are unsafe for an individual;

(D) Toys or outdoor play equipment; and

(E) Equipment and furnishings of general household use.

(4) ASSISTIVE TECHNOLOGY Assistive technology is primarily and customarily used to provide additional safety and support and replace the need for direct interventions, to enable self-direction of care, or increase independence. An individual who meets the general eligibility criteria in OAR 411-435-0030 may access this service when assistive technology may be reasonably expected to reduce the need for human assistance, or increase an individual's independence, with meeting an identified support need related to the completion of an ADL, IADL, or health related task.

(a) Expenditures for assistive technology are limited to $5,000 per plan year without Department approval. Any single purchase costing more than $500, or any combination of items that meet a single assessed need totaling more than $500, must be approved by the Department prior to expenditure. A case manager must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and a determination by the Department of appropriateness and cost-effectiveness.

(b) Payment for ongoing electronic back-up systems or assistive technology costs must be paid to providers each month after services are received.

(A) Ongoing costs do not include electricity or batteries.

(B) Ongoing costs may include minimally necessary data plans and the services of a company to monitor emergency response systems.

(c) Assistive technology includes, but is not limited to:

(A) Motion or sound sensors;

(B) Two-way communication systems;

(C) Automatic faucets and soap dispensers;

(D) Incontinence and fall sensors;

(E) Devices to secure assistance in an emergency in the community;

(F) Medication minders;

(G) Alert systems for ADL or IADL supports; or

(H) Mobile electronic devices or other electronic backup systems, including the expense necessary for the continued operation of the assistive technology.

(5) CHORE SERVICES.

(a) To be eligible to access chore services an individual must:

(A) Meet the general eligibility criteria in OAR 411-435-0030; and

(B) Not be enrolled in a residential program, unless the enrollment is in a supported living program described in OAR chapter 411, division 328 and the dwelling is not a provider owned, controlled, or operated setting.

(b) Chore services include heavy household chores, such as:

(A) Washing floors, windows, and walls;

(B) Tacking down loose rugs and tiles; and

(C) Moving heavy items of furniture for safe access and egress.

(c) 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.

(d) Chore services may be provided only in situations where no one else is responsible to perform or pay for the services.

(6) COMMUNITY TRANSPORTATION.

(a) Community transportation may only be authorized on an ISP when an individual meets the general eligibility criteria in OAR 411-435-0030, voluntary natural supports or volunteer services are not available, when the individual is not enrolled in a residential program, when it is not the responsibility of the parent of a child, and one of the following is identified in the ISP of the individual:

(A) The individual has an assessed need for ADL, IADL, or health-related task during transportation; or

(B) The individual has either an assessed need for ADL, IADL, or health-related task at the destination or a need for waiver funded services at the destination.

(b) Community transportation includes, but is not limited to:

(A) Community transportation provided by a common carrier, taxicab, or bus in accordance with standards established for these entities.

(B) Reimbursement on a per-mile basis for transporting an individual to accomplish ADL, IADL, a health-related task, or employment goal identified in an ISP.

(C) The purchase of a bus pass.

(c) Community transportation must be provided in the most cost effective manner which meets the needs identified in the ISP for the individual.

(d) Community transportation expenses exceeding $500 per month must be approved by the Department.

(e) Community transportation must be prior authorized by a case manager and documented in an ISP. The Department does not pay any provider under any circumstances for more than the total number of hours, miles, or rides prior authorized by the case manager and documented in the ISP. Personal support workers who use their own personal vehicle for community transportation are reimbursed as described in OAR chapter 411, division 375.

(f) Mileage reimbursement for community transportation is only authorized when a provider is also being paid for delivering community living supports or job coaching. Mileage may not be authorized as a stand-alone payment.

(g) Community transportation services exclude:

(A) Medical transportation;

(B) Purchase or lease of a vehicle;

(C) Routine vehicle maintenance and repair, insurance, and fuel;

(D) Ambulance services;

(E) Costs for transporting a person other than the individual;

(F) Transportation for a provider to travel to and from the workplace of the provider;

(G) Transportation that is not for the sole benefit of the individual;

(H) Transportation as part of a vacation or trips for relaxation purposes;

(I) Transportation provided by family members who are not personal support workers;

(J) Reimbursement for out-of-state travel expenses;

(K) Mileage reimbursement to the individual or a personal support worker when the individual owns the vehicle doing the transportation;

(L) Transportation normally provided by schools;

(M) Transportation normally provided by a primary caregiver for a child of similar age without disabilities; and

(N) Transportation for a child that is typically the responsibility of a parent. Transportation for a child that is not typically a parental responsibility is limited to transportation:

(i) Concurrent with the delivery of relief care as described in OAR 411-450-0060; or

(ii) Included in a Behavior Support Plan.

(7) TRANSITION COSTS.

(a) To be eligible to access transition costs an individual must meet the general eligibility criteria in OAR 411-435-0030 and not be enrolled in a residential program.

(b) Transition costs are limited to an individual transitioning from residing in a nursing facility or intermediate care facility for individuals with intellectual or developmental disabilities to residing in a community-based home when the cost for the service is not included in the rate paid to the provider.

(c) Transition costs are based on an the assessed need of an individual 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 transition costs must be through the Department prior to expenditure. The approval of the Department is based on the need of an individual and the determination by the Department of appropriateness and cost-effectiveness.

(d) Financial assistance for transition costs is limited to:

(A) Moving and move-in costs, including movers, cleaning and security deposits, payment for background or credit checks (related to housing), or 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, such as a bed; and

(C) Other items necessary to re-establish a home.

(e) Transition costs are provided no more than twice annually.

(f) Transitions costs for basic household furnishings and other items are limited to one time per year.

(g) Transition costs may not supplant the legal responsibility of the parent or guardian of a child. In this context, the term parent or guardian does not include a designated representative.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 20-2016, f. & cert. ef. 6-29-16

411-435-0060
Developmental Disabilities Waiver Services

The ancillary services described in this rule are available through the ICF/IDD Comprehensive Waiver, ICF/IDD Support Services Waiver, Medically Involved Children's Waiver, Medically Fragile (Hospital) Model Waiver, and Behavioral (ICF/IDD) Model Waiver.

(1) FAMILY TRAINING.

(a) To be eligible to access family training an individual must meet the general eligibility criteria in OAR 411-435-0030 and:

(A) Be enrolled in OSIPM; and

(B) Not be enrolled in a residential program.

(b) Family training services include:

(A) Instruction about treatment regimens and use of equipment specified in an ISP;

(B) Information, education, and training about the disability, medical, and behavioral conditions of an individual; and

(C) Registration fees for organized conferences and workshops specifically related to the intellectual or developmental disability of the individual or the identified, specialized, medical, or behavioral support needs of the individual.

(i) Conferences and workshops must be prior authorized by a case manager, directly relate to the intellectual or developmental disability of the individual, and increase the knowledge and skills of the family to care for and maintain the individual in the home of the individual.

(ii) Conference and workshop costs exclude:

(I) Travel, food, and lodging expenses;

(II) Services otherwise provided under OHP or available through other resources; or

(III) Costs for individual family members who are employed to care for the individual.

(c) Family training services exclude:

(A) Mental health counseling, treatment, or therapy;

(B) Training for a paid provider, including a paid family member;

(C) Legal fees;

(D) Training for a family 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 case manager is required for attendance by family members at organized conferences and workshops funded with Department funds.

(2) ENVIRONMENTAL SAFETY MODIFICATIONS.

(a) To be eligible to access environmental safety modifications an individual must meet the general eligibility criteria in OAR 411-435-0030 and:

(A) Be enrolled in OSIPM; and

(B) Not enrolled in a residential program, unless the enrollment is in a supported living program described in OAR chapter 411, division 328 and the dwelling is not a provider owned, controlled, or operated setting.

(b) Environmental safety modifications must be made using materials of the most cost effective type and may not include decorative additions.

(c) Fencing may not exceed 200 linear feet without approval from the Department.

(d) Environmental safety modifications exclude:

(A) Large gates, such as automobile gates;

(B) Costs for paint and stain;

(C) Adaptations or improvements to the home that are of general utility and are not for the direct safety or long-term benefit to the individual or do not address the underlying environmental need for the modification;

(D) Adaptations that add to the total square footage of the home; and

(E) Adaptations that are prohibited by local codes and ordinances or neighborhood Covenants, Conditions, and Restrictions (CCR).

(e) Environmental safety modifications must be tied to supporting ADL, IADL, and health-related tasks as identified in the ISP.

(f) Environmental safety modifications are limited to $5,000 per modification. A case manager must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-effectiveness. In addition, separate environmental safety modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(g) Environmental safety modifications must be completed by a state licensed contractor with a minimum of $1,000,000 liability insurance. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the file for the contractor prior to payment.

(h) Environmental safety modifications must be made within the existing square footage of the home and may not add to the square footage of the home.

(i) Payment to the contractor is to be withheld until the work meets specifications.

(j) A scope of work as defined in OAR 411-435-0020 must be completed for each identified environmental safety modification project. All contractors submitting bids must be given the same scope of work.

(k) For all environmental safety modifications, a minimum of three written bids from qualified providers as described in OAR 411-435-0080 are required.

(l) A case manager must follow the processes outlined in the In-home Expenditure Guidelines for contractor bids and the awarding of work.

(m) The identified home may not be in foreclosure or the subject of legal proceedings regarding ownership.

(n) Environmental safety modifications must only be completed to the primary residence of the individual.

(o) Upgrades in materials that are not directly related to the health and safety needs of the individual are not paid for or permitted.

(p) Environmental safety modifications are subject to Department requirements regarding material and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials manuals, and industry and risk management publications.

(q) RENTAL PROPERTY.

(A) Environmental safety modifications to rental property may not substitute or duplicate services otherwise the responsibility of the landlord under the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.

(B) Environmental safety modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.

(C) The Department does not fund work to restore the rental structure to the former condition of the rental structure.

(3) VEHICLE MODIFICATIONS.

(a) To be eligible to access vehicle modifications an individual must meet the general eligibility criteria in OAR 411-435-0030 and:

(A) Be enrolled in OSIPM; and

(B) Not be enrolled in a residential program.

(b) Vehicle modifications may only be made to the vehicle primarily used by an individual to meet the unique needs of the individual. Vehicle modifications may include a lift, interior alterations to seats, head and leg rests, belts, special safety harnesses, other unique modifications to keep the individual safe in the vehicle, and the upkeep and maintenance of a modification made to the vehicle.

(c) Vehicle modifications exclude:

(A) Adaptations or improvements to a vehicle that are of general utility and are not of direct medical benefit to the individual or do not address the underlying need for the modification;

(B) The purchase or lease of a vehicle; or

(C) Routine vehicle maintenance and repair.

(d) Vehicle modifications are limited to $5,000 per modification. A services coordinator must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the individual and the determination by the Department of appropriateness and cost-effectiveness. In addition, separate vehicle modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(e) Vehicle modifications must meet applicable standards of manufacture, design, and installation.

(4) SPECIALIZED MEDICAL SUPPLIES. Specialized medical supplies do not cover services which are otherwise available to an individual under Vocational Rehabilitation and Other Rehabilitation Services, 29 U.S.C. 701-7961, as amended, or the Individuals with Disabilities Education Act, 20 U.S.C. 1400 as amended. Specialized medical supplies may not overlap with, supplant, or duplicate other services provided through a waiver, OHP, or Medicaid state plan services. To be eligible to access specialized medical supplies an individual must meet the general eligibility criteria in OAR 411-435-0030 and be enrolled in OSIPM.

Stat. Auth.: ORS 409.050, 427.104, 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

Hist.: APD 20-2016, f. & cert. ef. 6-29-16

411-435-0070

Developmental Disabilities Other Waiver Services

(1) SPECIAL DIET. Special diets are specially prepared food or particular types of food, ordered by a physician and periodically monitored by a dietician, specific to the medical condition or diagnosis of an individual that are needed to sustain the individual in the home of the individual. Special diets are supplements and are not intended to meet the complete daily nutritional requirements of the individual. Special diet supplies must be supported by an evidence-based treatment regimen. This ancillary serv-

ice is available through the ICF/IDD Support Services Waiver, Medically Involved Children's Waiver, Medically Fragile (Hospital) Model Waiver, and Behavioral (ICF/IDD) Model Waiver.

(a) Specials diets are available to only individuals who meet the general eligibility criteria in OAR 411-435-0030 and are enrolled in OSIPM and a Brokerage or a CIIS program.

(b) A special diet is a supplement and is not intended to meet complete, daily nutritional requirements.

(c) A special diet must be ordered at least annually by a physician licensed by the Oregon Board of Medical Examiners and periodically monitored by a dietician or physician.

(d) The maximum monthly purchase for special diet supplies for a child in a CIIS program may not exceed $100 per month.

(e) Special diet supplies must be in support of an evidence-based treatment regimen.

(f) A special diet excludes restaurant and prepared foods, vitamins, and supplements.

(2) INDIVIDUAL-DIRECTED GOODS AND SERVICES. This ancillary service is available through the Medically Involved Children's Waiver, Medically Fragile (Hospital) Model Waiver, and Behavioral (ICF/IDD) Model Waiver.

(a) Only a child who meets the general eligibility criteria in OAR 411-435-0030 and is enrolled in CIIS may access individual-directed goods and services.

(b) Individual-directed goods and services provide equipment and supplies that are not otherwise available through another source, such as waiver services or state plan services.

(c) Authorization of individual directed goods and services must be based on an assessed need.

(d) Individual-directed goods and services must directly address an identified disability related need of a child in the ISP.

(e) Individual-directed goods and services must:

(A) Decrease the need for other Medicaid services;

(B) Promote inclusion of a child in the community; or

(C) Increase the safety of a child in the family home.

(f) Individual-directed goods and services may not be:

(A) Otherwise available through another source, such as waiver services or state plan services;

(B) Experimental or prohibited treatment; or

(C) Goods or services that are normally purchased by a family for a typically developing child of the same age.

(g) Individual-directed goods and services purchased must be the most cost effective option available to meet the needs of the child.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 20-2016, f. & cert. ef. 6-29-16

411-435-0080
Ancillary Service Provider Requirements

(1) Providers of community nursing services.

(a) Independent providers are not personal support workers and must meet the minimum qualifications of an independent provider described in OAR chapter 411 division 375 and:

(A) Have a current Oregon nursing license;

(B) Be enrolled in the Long Term Care Community Nursing Program as described in OAR chapter 411, division 048; and

(C) Submit a resume to the case management entity indicating the education, skills, and abilities necessary to provide nursing services in accordance with state law.

(b) Agency providers must be enrolled in the Long Term Care Community Nursing Program as described in OAR chapter 411, division 048.

(2) Providers delivering goods or services to individuals and paid with Department 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 providers of environmental modifications or environmental safety modifications 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) or OAR chapter 808 (Landscape Contractors Board) with a minimum of $1,000,000 liability insurance.

(b) 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.

(c) For public transportation providers, the established standards.

(d) For private transportation providers other than personal support workers, a business license and a license to drive in Oregon.

(e) For vendors and medical supply companies providing assistive devices or specialized medical supplies, a current retail business license, including enrollment as Medicaid providers through the Oregon Health Authority if vending medical equipment.

(f) Retail business licenses for vendors and supply companies providing special diets.

(3) Services provided and paid for with Department funds must be limited to the services within the scope of the license of the general business provider.

(4) A provider who is a writer of a scope of work, a contractor who is chosen to complete environmental modifications or environmental safety modifications, a contractor completing a vehicle modification, or a provider of chore services cannot have a conflict of interest associated with the delivery of the service unless the conflict is waived by the Department prior to delivering the service. A conflict of interest exists when the provider is:

(a) Related by blood or marriage to the individual, or to any paid caregiver of the individual.

(b) Financially responsible for the individual.

(c) Empowered to make financial or health-related decisions on behalf of the individual.

(d) May benefit financially from the provision of the environmental or vehicle modification.

(5) Payment by the Department for ancillary services is considered full payment for the services rendered under Medicaid. A provider may not demand or receive additional payment for ancillary services from the individual, legal representative, or any other source, under any circumstances.

(6) Medicaid funds are the payer of last resort. A provider must bill all third party resources until all third party resources are exhausted.

(7) The Department reserves the right to make a claim against any third party payer before or after making payment to the provider.

Stat. Auth.: ORS 409.050, 427.104, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 20-2016, f. & cert. ef. 6-29-16

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Rule Caption: ODDS: Adult Foster Homes for Individuals with Intellectual or Developmental Disabilities
Adm. Order No.: APD 21-2016
Filed with Sec. of State: 6-29-2016
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Rules Amended: 411-360-0010, 411-360-0020, 411-360-0050, 411-360-0055, 411-360-0060, 411-360-0110, 411-360-0140, 411-360-0160, 411-360-0170, 411-360-0180, 411-360-0190, 411-360-0200, 411-360-0260, 411-360-0130
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the rules in OAR chapter 411, division 360 for adult foster homes for individuals with intellectual or developmental disabilities.

These rules are being updated to:

- Make permanent temporary changes that became effective on January 1, 2016;

- Provide consistency across services by removing terms included in the general definitions rule, OAR 411-317-0000;

- Add clarifying language to the definition of a functional needs assessment;

- Clarify the authorization and administration of State Plan private duty nursing services by the Medically Fragile Children's Unit to support an individual aged 18 through 20;

- Incorporate direct nursing services to support an adult with complex health management support needs as described in OAR chapter 411, division 380;

- Incorporate the adoption of the rules for home and community-based (HCB) services and settings and person-centered service planning in OAR chapter 411, division 004;

- Require foster care providers to implement, as written by a behavior consultant, Behavior Support Plans and Interaction Guidelines;

- Incorporate changes to Bill of Rights language and requirements to match statutory language;

- Specify Individual Support Plan (ISP) participation requirements for foster care providers by removing the ISP requirements targeted for the case management entity;

- Clarify language to align the Medicaid benefits eligibility language under the qualifications for Department-funded services;

- Remove "crisis services" language; and

- Reflect current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

The rules in OAR chapter 411, division 004 implement the regulations and expectations of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) by providing a foundation of standards to support the network of Medicaid-funded and private pay residential and non-residential HCB services and settings and person-centered service planning.

Under the HCB setting standards, adult foster homes meet the definition of a provider owned, controlled, or operated residential setting. A provider initially licensed on or after January 1, 2016 must meet the requirements in OAR chapter 411, division 004 prior to being licensed. A provider licensed prior to January 1, 2016 must make measurable progress toward compliance with the rules in OAR chapter 411, division 004 and be in full compliance by September 1, 2018.

By September 1, 2018, all provider owned, controlled, or operated residential settings must have all the following qualities:

- The setting is integrated in and supports the same degree of access to the greater community as people not receiving HCB services, including opportunities for individuals enrolled in or utilizing HCB services to seek employment and work in competitive integrated employment settings, engage in greater community life, control personal resources, and receive services in the greater community;

- The setting is selected by an individual, or as applicable the legal or designated representative of the individual, from among available setting options, including non-disability specific settings and an option for a private unit in a residential setting;

- The setting ensures individual rights of privacy, dignity, respect, and freedom from coercion and restraint;

- The setting optimizes, but does not regiment, individual initiative, autonomy, self-direction, and independence in making life choices including, but not limited to, daily activities, physical environment, and with whom to interact;

- The setting facilitates individual choice regarding services and supports, and who provides the services and supports;

- The setting is physically accessible to an individual;

- The unit is a specific physical place that may be owned, rented, or occupied by an individual under a legally enforceable Residency Agreement;

- Each individual has privacy in his or her own unit;

- Units have entrance doors lockable by the individual, with the individual and only appropriate staff having a key to access the unit;

- Individuals sharing units have a choice of roommates;

- Individuals have the freedom to decorate and furnish his or her own unit as agreed to within the Residency Agreement;

- Individuals may have visitors of their choosing at any time;

- Each individual has the freedom and support to control his or her own schedule and activities; and

- Each individual has the freedom and support to have access to food at any time.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-360-0010
Statement of Purpose

(1) The rules in OAR chapter 411, division 360 prescribe the standards and procedures for the licensure of adult foster homes for individuals with intellectual or developmental disabilities (AFH-DD).

(2) These rules incorporate the provisions for home and community-based services (HCBS) and settings set forth in OAR chapter 411, division 004 to ensure individuals with intellectual or developmental disabilities receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving HCBS.

(a) An AFH-DD provider initially licensed on or after January 1, 2016 must meet the requirements in OAR chapter 411, division 004 prior to being licensed.

(b) An AFH-DD provider licensed prior to January 1, 2016 must make measurable progress toward compliance with the rules in OAR chapter 411, division 004 and be in full compliance by September 1, 2018.

(3) An AFH-DD facilitates individual choice regarding services and supports, and who provides the services and supports, through a cooperative relationship between the AFH-DD provider, the individual, the legal or designated representative of the individual (if applicable), and the Community Developmental Disability Program.

(4) An AFH-DD protects and encourages the independence, dignity, choice, and decision making of the individual while addressing the needs of the individual in a manner that supports and enables the individual to achieve optimum physical, mental, and social well-being and independence.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, 443.790
Stats. Implemented: ORS 443.705-825
Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 34-2013, f. & cert. ef. 9-27-13; APD 30-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0020
Definitions and Acronyms

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 360:

(1) "Adult Foster Home (AFH)" means any home in which residential care and services are provided in a home-like environment for compensation to five or fewer adults who are not related to the provider by blood, marriage, or adoption. An adult foster home does not include any house, institution, hotel, or other similar living situation that supplies room or board only, if no individual thereof requires any element of care.

(2) "Adult Foster Home for Individuals with Intellectual or Developmental Disabilities (AFH-DD)" means an adult foster home in which residential care and services are provided to support individuals with intellectual or developmental disabilities.

(3) "Advance Directive" or "Advance Directive for Health Care" means the legal document signed by an individual or the legal representative of the individual that provides health care instructions in the event the individual is no longer able to give directions regarding his or her wishes. The Advance Directive gives the individual the means to control his or her own health care in any circumstance. An Advance Directive for Health Care does not include Physician Orders for Life-Sustaining Treatment (POLST).

(4) "Advocate" means a person other than a paid caregiver who has been selected by an individual or the legal representative of the individual 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.

(5) "AFH-DD" means an "adult foster home for individuals with intellectual or developmental disabilities" as defined in this rule.

(6) "Applicant" means a person who completes an application for an adult foster home license who is also the owner of the business or a person who completes an application to become a resident manager. The term applicant includes a co-applicant (if applicable).

(7) "Bill of Rights" means civil, legal, or human rights afforded to individuals in an adult foster home that are in accordance with those rights afforded to all other U.S. citizens including, but not limited to, those rights delineated in the Adult Foster Home Bill of Rights for individuals with intellectual or developmental disabilities described in OAR 411-360-0170.

(8) "Care" means supportive services that encourage maximum individual independence and enhance the quality of life for an individual including, but not limited to:

(a) Provision of 24-hour supervision, being aware of the whereabouts of the individual, and ensuring the health, safety, and welfare of the individual;

(b) Assistance with activities of daily living as defined in OAR 411-317-0000;

(c) Assistance with instrumental activities of daily living as defined in OAR 411-317-0000;

(d) Assistance with quality of life activities, such as socialization and recreation; and

(e) Monitoring the activities of the individual to ensure the health, safety, and welfare of the individual.

(9) "Caregiver" means any person responsible for providing care and services to support individuals. A caregiver includes a provider, resident manager, and any temporary, substitute, or supplemental caregiver or other person designated to provide care and service to support individuals in an adult foster home for individuals with intellectual or developmental disabilities.

(10) "CDDP means "Community Developmental Disability Program".

(11) "CMS" means "Centers for Medicare and Medicaid Services".

(12) "Community Nursing Services" mean the nursing services that focus on the chronic and ongoing health and safety needs of an individual. Community nursing services include an assessment, monitoring, delegation, training, and coordination of services. Community nursing services are provided according to the rules in OAR chapter 411, division 048 and the Oregon State Board of Nursing rules in OAR chapter 851.

(13) "Compensation" means monetary or in-kind payments by or on behalf of an individual to a provider in exchange for room and board, care, and services as indicated in the ISP or Service Agreement. Compensation does not include the voluntary sharing of expenses between or among roommates.

(14) "Condition" means a provision attached to a new or existing license that limits or restricts the scope of the license or imposes additional requirements on the licensee.

(15) "Controlled Substance" means any drug classified as schedules one through five under the Federal Controlled Substance Act.

(16) "Day Care" means care, assistance, and supervision of an individual who does not stay overnight. Individuals receiving day care services are included in the licensed capacity of a home as described in OAR 411-360-0060.

(17) "Denial" means the refusal of the Department to issue a license to operate an adult foster home for individuals with intellectual or developmental disabilities because the Department has determined that an applicant or the home is not in compliance with one or more of these rules.

(18) "Disaster" means an occurrence beyond the control of a licensee, whether natural, technological, or man-made that renders a home uninhabitable on a temporary, extended, or permanent basis.

(19) "Domestic Animals" mean the animals domesticated so as to live and breed in a tame condition, such as dogs, cats, and domesticated farm stock.

(20) "Enjoin" means to prohibit by judicial order.

(21) "Exempt Area" means a county where there is a county agency that provides similar programs for licensing and inspection of adult foster homes that the Director finds are equal to or superior to the requirements of ORS 443.705 to 443.825 and that the Director has exempted from the license, inspection, and fee provisions described in ORS 443.705 to 443.825. Exempt area county licensing rules require review and approval by the Director prior to implementation.

(22) "Facility" means the physical structure of an adult foster home for individuals with intellectual or developmental disabilities.

(23) "Functional Needs Assessment":

(a) Means the comprehensive assessment or re-assessment that:

(A) Documents physical, mental, and social functioning;

(B) Identifies risk factors and support needs; and

(C) Determines the service level.

(b) A functional needs assessment may be:

(A) The Support Needs Assessment Profile (SNAP). The Department incorporates the SNAP into these rules by this reference. The SNAP is maintained by the Department at https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/PROVIDERS-PARTNERS/Pages/rebar-assessments.aspx;

(B) The Adult Needs Assessment (ANA). The Department incorporates Version C of the ANA into these rules by this reference. The ANA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm; or

(C) The Children's Needs Assessment (CNA). The Department incorporates Version C of the CNA into these rules by this reference. The CNA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm.

(c) A printed copy of the assessment tools may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

(24) "Guardian" means the parent for an individual less than 18 years of age or the person or agency appointed and authorized by a court to make decisions about services for the individual. A paid provider for an individual may not be the guardian of the individual.

(25) "Hearing" means a contested case hearing subject to OAR 137-003-0501 to 137-003-0070, which results in a Final Order.

(26) "Home" means the physical structure of an adult foster home for individuals with intellectual or developmental disabilities.

(27) "Homelike" means an environment that promotes the dignity, security, and comfort of individuals through the provision of personalized care and services to support and encourage independence, choice, and decision making by the individuals.

(28) "House Rules" mean the social courtesies identified through a voluntary collaborative process by members of the household. The identified rules are non-binding and may not be solely provider driven expectations for individuals residing in the home.

(29) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity.

(30) "Individual" means a young adult or adult residing in an adult foster home for individuals with intellectual or developmental disabilities, regardless of source of compensation.

(31) "Individualized Education Program" means the written plan of instructional goals and objectives developed in conference with an individual less than 21 years of age, the parent or legal representative of the individual (as applicable), teacher, and a representative of the public school district.

(32) "ISP" means "Individual Support Plan".

(33) "License" means a document granted by the Department to an applicant who is in compliance with the requirements of these rules.

(34) "Licensee" means the person who is issued a license, whose name is on the license, and who is responsible for the operation of an adult foster home. The licensee of an adult foster home does not include the owner or lessor of the building in which the adult foster home is situated unless the owner or lessor of the building is the provider.

(35) "Limited License" means a license is issued to a licensee who intends to provide care and services for compensation to a specific individual who is unrelated to the licensee but with whom the licensee has an established relationship of no less than one year.

(36) "Liquid Resource" means cash or those assets that may readily be converted to cash, such as a life insurance policy that has a cash value, stock certificates, or a guaranteed line of credit from a financial institution.

(37) "Marijuana" means all parts of the plant Cannabis family Moraceae, whether growing or not, the resin extracted from any part of the plant, and every compound, manufacture, salt derivative, mixture, or preparation of the plant or its resin. Marijuana does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted there from), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination. "Legal medical marijuana" refers to the use of marijuana authorized under the Oregon Medical Marijuana Act (OMMA), ORS 475.300 to 475.346.

(38) "Mental Health Assessment" means the assessment used to determine the need for mental health services by interviewing an individual and obtaining all pertinent biopsychosocial information as identified by the individual, the family of the individual, and collateral sources. A mental health assessment:

(a) Addresses the condition presented by the individual;

(b) Determines a diagnosis; and

(c) Provides treatment direction and individualized services and supports.

(39) "Modified Diet" means the texture or consistency of food or drink is altered or limited, such as no nuts or raw vegetables, thickened fluids, mechanical soft, finely chopped, pureed, or bread only soaked in milk.

(40) "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. Nursing services differ from administrative nursing services.

(41) "OCCS" means the "Oregon Health Authority, Office of Client and Community Services".

(42) "Occupant" means any person residing in or using the facilities of an adult foster home including the individuals, licensee, resident manager, friends, family members, a person receiving day care services, and room and board tenants.

(43) "OIS" means the "Oregon Intervention System".

(44) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(45) "Over the Counter Topical" means a medication that is purchased without a prescription and is applied to the skin and not in an orifice.

(46) "Ownership Interest" means the possession of equity in the capital, stock, or profits of an adult foster home. A person with an ownership or control interest means a person or corporation that:

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

(47) "Provider" means any person operating an adult foster home, such as a licensee or resident manager. "Provider" does not include caregivers or the owner or lessor of the building in which an adult foster home is situated unless the owner or lessor of the building is also the operator of the adult foster home.

(48) "Provider Enrollment" means an agreement between the Department and a Medicaid provider to provide room and board and care and services for compensation to support a Medicaid eligible individual in an adult foster home.

(49) "Provisional License" means a 60-day license issued in an emergency situation when a licensed provider is no longer overseeing the operation of an adult foster home. A provisional license is issued to a qualified person who meets the standards of OAR 411-360-0070 and 411-360-0110.

(50) "Qualified Entity Initiator (QEI)" has the meaning set forth in OAR 407-007-0210 (Criminal Records and Abuse Checks for Providers).

(51) "Qualified Mental Health Professional" means a licensed medical practitioner or any other person meeting the qualifications specified in OAR 309-019-0125.

(52) "Relief Care" means the intermittent services that are provided on a periodic basis for the relief of, or due to the temporary absence of, a person normally providing care and services to support an individual. Relief care may include 24-hour relief care or hourly relief care. Individuals receiving relief care are included in the licensed capacity of a home as described in OAR 411-360-0060.

(53) "Reside" means for a person to live in an adult foster home for a permanent or extended period of time. For the purpose of a background check, a person is considered to reside in a home if the visit of the person is for four consecutive weeks or greater.

(54) "Resident Manager" means an employee of a licensee approved by the Department, who resides in an adult foster home and is directly responsible for the care and services to support individuals on a day-to-day basis.

(55) "Respite" means "relief care" as defined in this rule.

(56) "Revocation" means the action taken by the Department to rescind an adult foster home license after the Department determines the provider or home is not in compliance with one or more of these rules.

(57) "Room and Board" means receiving compensation for the provision of meals, a place to sleep, laundry, basic utilities, and housekeeping to a person that does not need assistance with activities of daily living. Room and board facilities for two or more people are required to register with the Department as described in OAR chapter 411, division 068, unless registered with the local authority having jurisdiction. Room and board does not include provision of care.

(58) "Self-Preservation" in relation to fire and life safety means the ability of an individual to respond to an alarm without additional cues and reach a point of safety without assistance.

(59) "Special Diet" means the specially prepared food or particular types of food that are specific to the medical condition or diagnosis of an individual and in support of an evidence-based treatment regimen. Examples include, but are not limited to, low calorie, high fiber, diabetic, low salt, lactose free, or low fat diets. A special diet does not include a diet where extra or additional food is offered without the order of a physician or licensed health care provider but may not be eaten, such as offering prunes each morning at breakfast or including fresh fruit with each meal.

(60) "Subject Individual" means:

(a) Any person 16 years of age or older, including:

(A) A licensed adult foster home provider and provider applicant;

(B) A person intending to work in or currently working in an adult foster home, including but not limited to a substitute caregiver and a potential substitute caregiver in training;

(C) A volunteer if allowed unsupervised access to an individual; and

(D) An occupant, excluding an individual, residing in or on the premises of a proposed or currently licensed adult foster home, including:

(i) A member of the household;

(ii) A room and board tenant; and

(iii) A person visiting for four consecutive weeks or greater.

(b) Subject individual does not apply to:

(A) An individual of the adult foster home or a visitor of an individual;

(B) A person who resides or works in an adult foster home who does not have:

(i) Regular access to the home for meals;

(ii) Regular use of the appliances or facilities of the adult foster home; or

(iii) Unsupervised access to an individual or the personal property of an individual.

(C) A person providing services to an individual that is employed by a private business not regulated by the Department.

(61) "Substitute Caregiver" means any person who provides care and services in an adult foster home under the jurisdiction of the Department that is left in charge of the individuals for any period of time and has access to the individuals' records.

(62) "Suspension" means an immediate, temporary withdrawal of the approval to operate an adult foster home after the Department determines a provider or home is not in compliance with one or more of these rules or there is a threat to the health, safety, or welfare of individuals.

(63) "Tenant" means an individual who resides in an adult foster home and receives services, such as meal preparation, laundry, and housekeeping.

(64) "These Rules" mean the rules in OAR chapter 411, division 360.

(65) "Urgent Medical Need" means the onset of psychiatric or medical symptoms requiring attention within 48 hours to prevent a serious deterioration in the mental or physical condition of an individual.

(66) "Variance" means the temporary exemption from a regulation or provision of these rules that may be granted by the Department upon written application by the provider.

(67) "Young Adult" means a young individual age 18 through 21 who resides in an adult foster home under the custody of the Department, voluntarily, or under guardianship. A young adult may include an individual who is less than 18 years of age.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, & 443.790

Stats. Implemented: ORS 443.705 - 443.825

Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 34-2013, f. & cert. ef. 9-27-13; APD 28-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 47-2014, f. 12-26-14, cert. ef. 12-28-14; APD 30-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0050
License Application and Fees

(1) An applicant for an AFH-DD license must complete a written application on forms supplied by the Department and submit the application to the Department with the non-refundable fee.

(a) The application is not complete until the required information is submitted to the Department with the required non-refundable fee. Incomplete applications are void after 60 days from the date the application form is received by the Department.

(b) Failure to provide accurate information may result in the denial of the application.

(2) A separate application is required for each location where an AFH-DD is to be operated.

(3) An application for an AFH-DD that has a resident manager must include a completed application for the resident manager on the form supplied by the Department.

(4) The application for an AFH-DD license must include:

(a) The maximum capacity as described in OAR 411-360-0060;

(b) A list of all persons that reside in the home that receive care including family members that reside in the home that require care and persons receiving respite, relief care, and day care services;

(c) A list of all other occupants that reside in the home or on the property of the home, including family members, friends, and room and board tenants;

(d) The statement of a health care provider on the form supplied by the Department regarding the ability of the applicant to provide care and services;

(e) Financial information including:

(A) A completed Financial Information Sheet on the form supplied by the Department;

(i) An applicant must have the financial ability and maintain sufficient liquid resources to pay the operating costs of an AFH-DD for at least two months without solely relying on potential income from individuals and room and board payments.

(ii) If an applicant is applying to operate more than one AFH-DD, the applicant must demonstrate the financial ability and maintain sufficient liquid resources to pay the operating costs of all the homes for at least two months without solely relying on potential income from individuals and room and board payments.

(iii) If an applicant is unable to demonstrate the financial ability and resources required by this section of this rule, the Department may require the applicant to furnish a financial guarantee such as a line of credit or guaranteed loan to fulfill the requirements of this rule.

(B) Documentation of all unsatisfied judgments, liens, and pending lawsuits in which a claim for money or property is made against the applicant;

(C) Documentation of all bankruptcy filings by the applicant;

(D) Documentation of all unpaid taxes due from the applicant including but not limited to, property taxes, employment taxes, and state and federal income taxes;

(E) Copies of bank statements from the last three months demonstrating banking activity in both checking and savings accounts as applicable or demonstration of cash on hand may be requested; and

(F) A copy of a complete and current credit report for the applicant may be requested.

(f) If the home is leased or rented, a copy of the signed and dated lease or rental agreement. The agreement must be a standard lease or rental agreement for residential use and include the following:

(A) The name of the owner and landlord;

(B) Verification that the rent is a flat rate; and

(C) Signatures of the landlord and applicant and date signed.

(g) If the applicant is purchasing or owns the home, verification of purchase or ownership;

(h) A current and accurate floor plan for the home that indicates:

(A) The size of the rooms;

(B) The size of the windows;

(C) Which bedrooms are to be used by individuals, the licensee, caregivers, room and board tenants (as applicable), and for day care, relief care, and respite services;

(D) The location of all the exits on each level of the home, including emergency exits such as windows;

(E) The location of any wheelchair ramps;

(F) The location of all fire extinguishers, smoke alarms, and carbon monoxide alarms;

(G) Planned evacuation routes; and

(H) Any designated smoking areas in or on the premises of the home.

(i) If requesting a license to operate more than one AFH-DD, a plan covering administrative responsibilities and staffing qualifications for each home;

(j) Three personal references for the applicant. The personal references may not be family members, current or potential licensees, or co-workers of current or potential licensees;

(k) A written description of the daily operation of the AFH-DD including:

(A) The schedule of the provider, resident manager, and substitute caregivers; and

(B) A plan of coverage for the absence of the provider, resident manager, and substitute caregivers.

(l) Written information describing the operational plan for the AFH-DD including:

(A) The use of a substitute caregiver, if applicable; and

(B) A plan of coverage for the absence of the resident manager, if applicable;

(m) A signed background check and if needed, the mitigating information and fitness determination form for each person who is to have regular contact with the individuals, including the provider, the resident manager, caregivers, and other occupants of the home over the age of 16 (excluding individual service recipients);

(n) A signed consent form for a background check with regards to abuse of children;

(o) Founded reports of child abuse or substantiated abuse allegations with dates, locations, and resolutions of those reports for all persons that reside in the home, as well as all applicant or provider employees, independent contractors, and volunteers;

(p) The classification being requested with information and supporting documentation regarding qualifications, relevant work experience, and training of caregivers as required by the Department;

(q) A $20.00 per bed non-refundable fee for each individual service recipient (includes all private pay and publicly funded individuals, but does not include day care and family members);

(r) A copy of the Residency Agreement for the AFH-DD; and

(s) A mailing address if different from the address of the AFH-DD and a business address for electronic mail.

(5) After receipt of the completed application materials, including the non-refundable fee, the Department investigates the information submitted and inspects the home. Compliance with these rules is determined upon submission and completion of the application and the process described.

(a) The applicant is given a copy of the inspection form identifying any areas of noncompliance and specifying a timeframe for correction, but no later than 60 days from the date of inspection.

(b) Deficiencies noted during an inspection of the home must be corrected in the timeframe specified by the Department. Applicants must be in compliance with these rules before a license is issued. An application is denied if cited deficiencies are not corrected within the timeframes specified by the Department.

(6) Applicants must attend a local orientation offered by the local CDDP prior to being licensed.

(7) An applicant may withdraw a new or renewal application at any time during the application process by notifying the Department in writing.

(8) An applicant whose license has been revoked, non-renewed, or voluntarily surrendered during a revocation or non-renewal process, or whose application has been denied, may not be permitted to make a new application for one year from the date that the action is final, or for a longer period of time if specified in the final order.

(9) All monies collected under these rules are to be paid to the Quality of Care Fund.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, & 443.790

Stats. Implemented: ORS 443.705 - 443.825

Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 34-2013, f. & cert. ef. 9-27-13; APD 30-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0055

Provider Enrollment Agreements, Contracts, and Residency Agreements

(1) MEDICAID PROVIDER ENROLLMENT AGREEMENT.

(a) An applicant or licensee who intends to provide care and services to support individuals who are or become eligible for Medicaid services must enter into a Medicaid Provider Enrollment Agreement with the Department, follow Department rules, and abide by the terms of the Agreement. A Medicaid Provider Enrollment Agreement is not approved unless the Department has determined that the applicant, licensee, co-licensee, or any owner or officer of the corporation, as applicable, is not listed on the Exclusion Lists for the Office of Inspector General or the U.S. General Services Administration (System for Award Management).

(b) An approved Medicaid Provider Enrollment Agreement does not guarantee the placement of individuals eligible for Medicaid services in an AFH-DD.

(c) An approved Medicaid Provider Enrollment Agreement is valid for the length of the license unless earlier terminated by the licensee or the Department. A Medicaid Provider Enrollment Agreement must be completed, submitted, approved, and renewed with each licensing cycle.

(d) An individual eligible for Medicaid services may not be admitted into an AFH-DD unless and until the Department has approved a Medicaid Provider Enrollment Agreement. Medicaid payment is not issued to a licensee without a current license and an approved Medicaid Provider Enrollment Agreement in place.

(e) The rate of compensation established by the Department is considered payment in full. The licensee may not request or accept additional funds or in-kind payment from any source.

(f) The Department does not issue payment for the date of the exit of an individual or for any time period thereafter.

(g) The licensee or the Department may terminate a Medicaid Provider Enrollment Agreement according to the terms of the Agreement.

(h) The Department may terminate a Medicaid Provider Enrollment Agreement under the following circumstances:

(A) The licensee fails to maintain substantial compliance with all related federal, state, and local laws, ordinances, and regulations; or

(B) The license to operate the AFH-DD has been voluntarily surrendered, revoked, or not renewed.

(i) The Department must terminate a Medicaid Provider Enrollment Agreement under the following circumstances:

(A) The licensee fails to permit access by the Department or CMS to any AFH-DD licensed to and operated by the licensee;

(B) The licensee submits false or inaccurate information;

(C) Any person with five percent or greater direct or indirect ownership in the AFH-DD did not submit timely and accurate information on the Medicaid Provider Enrollment Agreement form or fails to submit fingerprints if required under the background check rules in OAR 407-007-0200 to 407-007-0370;

(D) Any person with five percent or greater direct or indirect ownership interest in the AFH-DD has been convicted of a criminal offense related to his or her involvement with Medicare, Medicaid, or Title XXI programs in the last 10 years; or

(E) Any person with an ownership or control interest, or who is an agent or managing employee of the AFH-DD fails to submit timely and accurate information on the Medicaid Provider Enrollment Agreement form.

(j) If a licensee submits notice of termination of the Medicaid Provider Enrollment Agreement, the licensee must concurrently issue a Notice of Involuntary Move or Transfer to each individual eligible for Medicaid services residing in the AFH-DD.

(k) If either a licensee or the Department terminates the Medicaid Provider Enrollment Agreement, the licensee may not re-apply for a new Medicaid Provider Enrollment Agreement for a period of no less than 180 days from the date the licensee or the Department terminated the Agreement.

(l) A licensee must forward all of the personal incidental funds (PIF) of an individual who is a recipient of Medicaid services within 10 business days of the death of the individual to the Estate Administration Unit, PO Box 14021, Salem, Oregon 97309-5024.

(2) PRIVATE PAY CONTRACT. A licensee who provides care and services to support individuals who pay with private funds or individuals receiving only day care services must enter into a written contract with the individual or the person paying for the care and services of the individual. The written contract is the admission agreement. The written contract must be signed by all parties prior to the admission of the individual and updated as needed. A copy of the contract is subject to review by the Department prior to licensure and prior to the implementation of any changes to the contract.

(a) The contract must include but not be limited to:

(A) A person-centered service plan;

(B) A schedule of rates; and

(C) Conditions under which the rates may be changed.

(b) The provider must give a copy of the signed contract to the individual, or as applicable the legal representative of the individual and retain the original contract in the record for the individual.

(c) The licensee must give written notice to a private pay individual, or as applicable the person paying for the care and services of the individual, 30 days prior to any general rate increases, additions, or other modifications of the rates unless the change is due to a medical emergency resulting in a greater level of care in which case the notice must be given within 10 days of the change.

(3) RESIDENCY AGREEMENT.

(a) The licensee must enter into a written Residency Agreement with each individual specifying, at a minimum, the following:

(A) The eviction process, notice requirements, and appeal rights available to each individual;

(B) The right of the individual to furnish and decorate his or her bedroom, subject to the limitations specified herein; and

(C) Policies and conditions for the following:

(i) Designated smoking areas. Use of tobacco must be in compliance with the Oregon Indoor Clean Air Act and OAR 411-360-0130;

(ii) Use and presence of medical marijuana in compliance with the Oregon Medical Marijuana Act and OAR 411-360-0140. The Residency Agreement expectations for medical marijuana must be reviewed and approved by the Department. If an individual intends to use medical marijuana in the AFH-DD, the Residency Agreement including guidelines for medical marijuana must be signed and dated by the individual or the legal representative of the individual and included in the record for the individual;

(iii) Restriction related to pets, if any;

(iv) Monthly charges and services to be provided; and

(v) Refunds in case of departure or death.

(b) The Residency Agreement may not violate the rights of an individual as stated in ORS 430.210, 443.739, OAR 411-360-0170, and 411-318-0010.

(c) The Residency Agreement may not be in conflict with any of these rules or the rules in OAR chapter 411, division 004 for home and community-based services and settings.

(d) Prior to implementing changes to the Residency Agreement, the Residency Agreement may be subject to review by the Department or the designee of the Department.

(e) The provider must review and provide a copy of the Residency Agreement to each individual, and as applicable the legal representative of the individual, at the time of entry and annually or as changes occur. The reviews must be documented by having the individual, or as applicable the legal representative of the individual, sign and date a copy of the Residency Agreement. A copy of the signed and dated Residency Agreement must be maintained in the record for the individual.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, 443.790
Stats. Implemented: ORS 443.705-825
Hist.: SPD 34-2013, f. & cert. ef. 9-27-13; APD 30-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0060
Capacity

(1) The maximum capacity of an AFH-DD is limited to five individuals who require care and services who are unrelated to the provider by blood, marriage, or adoption.

(2) The number of individuals permitted to reside in an AFH-DD is determined by the ability of the caregiver to meet the care, service, and support needs of the individuals, fire safety standards, physical structure standards, and the standards of these rules.

(a) Determination of maximum capacity includes consideration of total household composition including all children, adult relatives, and older adults.

(b) In determining maximum capacity, consideration is given to whether children over the age of 5 have a bedroom separate from their parents and the number and age of children or others that reside in the AFH-DD requiring care.

(3) Children under the age of 10 living in the AFH-DD and individuals requiring relief care, attendant care, or skills training services are included in the licensed capacity of the AFH-DD.

(4) A provider may only exceed the licensed capacity of the AFH-DD by one or more individuals if:

(a) Approved by the Department;

(b) There is adequate bedroom and living space available in the AFH-DD for the individuals receiving services; and

(c) The total capacity does not exceed five.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, 443.790
Stats. Implemented: ORS 443.705-825
Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 34-2013, f. & cert. ef. 9-27-13; APD 30-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0110
Qualifications for Providers, Resident Managers, and Caregivers

(1) PROVIDER QUALIFICATIONS. An AFH-DD provider must meet the level requirements of the AFH-DD license as described in OAR 411-360-0070 and the following qualifications:

(a) Be at least 21 years of age;

(b) Reside in the home that is to be licensed as the AFH-DD or if the provider does not reside in the home there must be a resident manager who resides in the home. A provider or resident manager resides in the home when the provider or resident manager sleeps in the home four nights per week;

(c) Provide evidence satisfactory to the Department regarding experience, training, knowledge, interest, and concern in providing care and services to support individuals with intellectual or developmental disabilities. Such evidence may include, but not be limited to:

(A) Certified nurse's aide training;

(B) Nursing home, hospital, or institutional work experience;

(C) Licensed practical nurse or registered nurse training and experience;

(D) Training approved by the Department; or

(E) Experience providing care and services and home management skills to individuals with intellectual or developmental disabilities.

(d) Possess the physical health, mental health, good judgment, and good personal character determined necessary by the Department to provide 24-hour care and services to support individuals with intellectual or developmental disabilities. A provider must have a statement from a health care provider, on a form provided by the Department, indicating that the provider is physically and mentally capable of providing care and services. A provider with a documented history or substantiated complaints of substance abuse or mental illness must provide evidence satisfactory to the Department of successful treatment and rehabilitation and references regarding current condition;

(e) Have an approved background check annually as required in section (2) of this rule and maintain that approval as required;

(f) Have no founded reports of child abuse or a substantiated abuse allegation;

(g) Have the financial ability and maintain sufficient liquid resources to pay the operating costs of the AFH-DD for at least two months without solely relying on potential income from individuals and room and board payments. If a provider operates more than one AFH-DD, the provider must have the financial ability and maintain sufficient liquid resources to pay the operating costs of all the AFH-DDs for at least two months without solely relying on potential income from individuals and room and board payments;

(A) Upon application, documentation of the following must be provided to the Department:

(i) All unsatisfied judgments, liens, and pending lawsuits in which a claim for money or property is made against the applicant;

(ii) All bankruptcy filings by the applicant; and

(iii) All unpaid taxes due from the applicant including but not limited to property taxes, employment taxes, and state and federal income taxes.

(B) The Department may require or permit the applicant to provide a current credit report to satisfy this financial requirement.

(C) The Department may not issue an initial license to an applicant who has been adjudged bankrupt more than once.

(D) If an applicant has any unpaid judgments (other than a current judgment for support), pending lawsuits, liens, or unpaid taxes, proof that the applicant has the amount of resources necessary to pay those claims must be provided to the Department as required.

(E) If an applicant is unable to demonstrate the financial ability and resources as required, the Department may require the applicant to furnish a financial guarantee such as a line of credit or guaranteed loan as a condition of initial licensure.

(h) Be literate in the English language and demonstrate the ability to comprehend and communicate in English orally and in writing with the individuals, licensed health care providers, services coordinators, and others involved in the care of the individuals;

(i) Be able to respond appropriately to emergency situations at all times;

(j) If transporting individuals by motorized conveyance, have a current license to drive in compliance with the laws of the Department of Motor Vehicles and vehicle insurance as required by the state of Oregon;

(k) Document annual review of responsibility for mandatory reporting of abuse or neglect of an individual on forms provided by the Department;

(l) Have a clear understanding of the job responsibilities, knowledge of the individuals' ISPs or Service Agreements, and the ability to provide the care and services specified for each individual; and

(m) Not be listed on the Exclusion Lists of the Office of Inspector General or General Services Administration.

(2) BACKGROUND CHECKS.

(a) In accordance with OAR 407-007-0200 to 407-007-0370 and under ORS 181.534, all subject individuals as defined in OAR 411-360-0020 must have an approved background check prior to operating or working, training, or residing in an AFH-DD:

(A) Annually;

(B) Prior to a change in the position of a subject individual (i.e. changing from a caregiver to resident manager); and

(C) Prior to working in another AFH-DD regardless of whether the employer is the same or not unless subsection (b) of this section applies.

(b) PORTABILITY OF BACKGROUND CHECK APPROVAL. A subject individual, excluding licensees, may be approved to work in multiple homes within a county only when the subject individual is working in the same employment role. The indication of worksite location must be included by a qualified entity initiator for each subject individual to show the intent of the subject individual to work at various AFH-DDs within the licensing jurisdiction of the county.

(c) Public funds may not be used to support, in whole or in part, a provider, a resident manager, employees of the provider, alternate caregivers, volunteers, or any other subject individual under OAR 407-007-0200 to 407-007-0370 who is subject to background checks, who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275. This rule does not apply to caregivers of an AFH-DD hired prior to July 28, 2009.

(d) A person may not be authorized as a provider or meet qualifications as described in this rule if the person is subject to background checks and has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275. This rule does not apply to caregivers of the AFH-DD hired prior to July 28, 2009.

(e) A weighing test is applied to background checks for occupants who do not provide care in the AFH-DD but require a background check on or after July 28, 2009 for approval purposes.

(3) RESIDENT MANAGER REQUIREMENTS. A resident manager must meet the provider qualifications listed in section (1) of this rule and the level requirements of the AFH-DD license as described in OAR 411-360-0070.

(4) SUBSTITUTE CAREGIVER REQUIREMENTS. A substitute caregiver must meet the level requirements of the AFH-DD license as described in OAR 411-360-0070 and the following qualifications:

(a) Be at least 18 years of age;

(b) Have an approved background check annually as required in section (2) of this rule and maintain that approval as required. A person may not be authorized as a substitute caregiver or meet qualifications as described in this rule if the person has been hired on or after July 28, 2009, or is subject to a background check beginning July 28, 2009 as required by administrative rule, and the person has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275;

(c) Be notified annually of the responsibility of the substitute caregiver as a mandatory reporter of abuse or neglect. Annual mandatory reporter notification must be documented on forms provided by the Department;

(d) Be literate in the English language and demonstrate the ability to comprehend and communicate in English orally and in writing with the individuals, licensed health care providers, services coordinators, and others involved in the care of the individuals;

(e) Be able to respond appropriately to emergency situations at all times;

(f) Know fire safety and emergency procedures;

(g) Have a clear understanding of the job responsibilities, knowledge of the individuals' ISPs or Service Agreements, and the ability to provide the care and services specified for each individual's needs;

(h) Be able to meet the qualifications of a resident manager described in section (4) of this rule when left in charge of an AFH-DD for 30 days or longer;

(i) Not be an individual service recipient of the AFH-DD;

(j) If transporting individuals by motorized conveyance, have a current license to drive in compliance with the laws of the Department of Motor Vehicles and vehicle insurance as required by the state of Oregon;

(k) Possess the physical health, mental health, good judgment, and good personal character determined necessary by the Department to provide care and services to support individuals with intellectual or developmental disabilities. A substitute caregiver with a documented history or substantiated complaints of substance abuse or mental illness must provide evidence satisfactory to the Department of successful treatment and rehabilitation and references regarding current condition;

(l) Must meet the training requirements of the level of the AFH-DD license in OAR 411-360-0120; and

(m) Must disclose on an application for employment if they have been found to have committed abuse.

(5) A licensee may not hire or continue to employ a resident manager or substitute caregiver that does not meet the requirements stated in this rule.

(6) The licensee is responsible for the operation of the AFH-DD and the quality of care and services rendered in the AFH-DD.

(7) The licensee is responsible for the supervision and training of resident managers and substitute caregivers and their general conduct when acting within the scope of their employment or duties.

(8) A licensee, resident manager, caregiver, volunteer, or other subject individual must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and 407-007-0290. The person must notify the Department within 24 hours.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, & 443.790
Stats. Implemented: ORS 443.705 - 443.825
Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; 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 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 34-2013, f. & cert. ef. 9-27-13; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0130
AFH-DD Standards

In order to qualify for or renew a license, an AFH-DD must meet the following provisions.

(1) GENERAL CONDITIONS.

(a) Each AFH-DD must maintain up-to-date documentation verifying the AFH-DD meets applicable local business license, zoning, building, and housing codes, and state and local fire and safety regulations for a single-family residence. General buildings must be of sound construction and meet all applicable state and local fire and safety regulations in effect at the time of construction. It is the duty of the provider to check with local government to be sure all applicable local codes have been met. A current floor plan of the house must be on file with the local CDDP.

(b) Mobile homes must have been built since 1976 and designed for use as a home rather than a travel trailer. The mobile home must have the label from the manufacturer permanently affixed to the home that states the mobile home meets the requirements of the Department of Housing and Urban Development (HUD) or authority having jurisdiction.

(c) The building, patios, decks, walkways, and furnishings must be clean and in good repair. The interior and exterior must be well maintained and accessible according to the needs of the individuals residing in the home. Walls, ceilings, and floors must be of such character to permit frequent washing, cleaning, or painting, as appropriate. There must be no accumulation of garbage, debris, rubbish, or offensive odors.

(d) Stairways (interior and exterior) must have handrails and be adequately lighted. Yard and exterior steps must be accessible and appropriate to the needs of the individuals residing in the home.

(e) Adequate lighting must be provided in each room, internal and external stairways, and internal and external exit ways. Incandescent light bulbs and florescent tubes must be protected and installed per the directions of the manufacturer.

(f) The heating system must be in working order. Areas of the AFH-DD used by individuals must be maintained at a comfortable temperature. Minimum temperatures during the day (when individuals are home) must be no less than 68 degrees F and no less than 60 degrees at night when individuals are sleeping. During times of extreme summer heat, the provider must make every reasonable effort to make the individuals comfortable and safe using ventilation, fans, or air conditioners. The temperature may not exceed 85 degrees in the house.

(g) There must be at least 150 square feet of common space and sufficient comfortable furniture in the AFH-DD to accommodate the recreational and socialization needs of the occupants at one time. Common space may not be located in the basement or in garages unless such space was constructed for that purpose or has otherwise been legalized under permit. Additional space may be required if wheelchairs are to be accommodated.

(h) Providers must not permit individuals to access or use swimming or other pools, hot tubs, saunas, or spas on the AFH-DD premise without supervision. Swimming pools, hot tubs, spas, or saunas must be equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.

(i) Hallways and exit ways must be at least 36 inches wide or as approved by the authority having jurisdiction. Interior doorways used by individuals must be wide enough to accommodate wheelchairs and walkers if used by individuals.

(j) Only ambulatory individuals capable of self-preservation may be housed on a second floor or in a basement.

(k) Split level homes must be evaluated according to accessibility, emergency egress, and evacuation capability of the individuals.

(l) Ladders, rope, chain ladders, and other devices may not be used as a secondary means of egress.

(m) Marijuana must not be grown in or on the premises of the AFH-DD. Individuals with Oregon Medical Marijuana Program (OMMP) registry cards must arrange for and obtain their own supply of medical marijuana from a designated grower as authorized by OMMP. The licensed provider, the caregiver, other employee, or any occupant in or on the premises of the AFH-DD must not be designated as the grower for and individual and must not deliver marijuana from the supplier.

(2) SANITATION.

(a) A public water supply must be utilized if available. If a non-municipal water source is used, the water source must be tested for coliform bacteria by a certified agent yearly and records must be retained for two years. Corrective action must be taken to ensure potability.

(b) Septic tanks or other non-municipal sewage disposal systems must be in good working order.

(c) Garbage and refuse must be suitably stored in readily cleanable, rodent proof, covered containers, pending weekly removal.

(d) Prior to laundering, soiled linens and clothing must be stored in containers in an area separate from food storage, kitchen, and dining area. Special pre-wash attention must be given to soiled and wet bed linens.

(e) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards. Proof of current rabies or other vaccinations as required by a licensed veterinarian must be maintained on the premises. Pets not confined in enclosures must be under control and must not present a danger or health risk to individuals or guests.

(f) There must be adequate control of insects and rodents, including screens in good repair on doors and windows used for ventilation.

(g) Universal precautions for infection control must be followed in care to individuals. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood or other body fluids.

(h) All caregivers must take precautions to prevent injuries caused by needles and other sharp instruments or devices during procedures. After they are used, disposable syringes and needles and other sharp items must be placed in puncture-resistant containers for disposal. The puncture-resistant containers must be located as close as practical to the use area. Disposal must be according to local regulations and resources (ORS 459.386 to 459.405).

(3) BATHROOMS. Bathrooms must:

(a) Provide for individual privacy and have a finished interior, a mirror, a window capable of being opened or other means of ventilation, and a window covering. No person must have to walk through the bedroom of another person to access a bathroom;

(b) Be clean and free of objectionable odors;

(c) Have tubs or showers, toilets, and sinks in good repair. A sink must be located near each toilet. A toilet and sink must be provided on each floor where rooms of non-ambulatory individuals or individuals with limited mobility are located. There must be at least one toilet, one sink, and one tub or shower for each six household occupants, including the provider and the family of the provider;

(d) Have hot and cold water in sufficient supply to meet the needs of the individuals for personal hygiene. Hot water temperature sources for bathing areas may not exceed 120 degrees F;

(e) Have shower enclosures with nonporous surfaces. Glass shower doors must be tempered safety glass. Shower curtains must be clean and in good condition. Non-slip floor surfaces must be provided in tubs and showers;

(f) Have grab bars for toilets, tubs, and showers for the safety of individuals as required by the disabilities of the individuals;

(g) Have barrier-free access to toilet and bathing facilities with appropriate fixtures if there are non-ambulatory individuals in the AFH-DD. Alternative arrangements for non-ambulatory individuals must be appropriate to individual needs for maintaining good personal hygiene;

(h) Have adequate supplies of toilet paper for each toilet and soap for each sink; and

(i) Individuals must be provided with individual towels and wash cloths that are laundered in hot water at least weekly or more often if necessary. Individuals must have appropriate racks or hooks for drying bath linens. If individual hand towels are not provided, individuals must be provided with individually dispensed paper towels.

(4) BEDROOMS.

(a) Bedrooms for all household occupants must:

(A) Have been constructed as a bedroom when the home was built or remodeled under permit;

(B) Have a finished interior with walls or partitions of standard construction that go from floor to ceiling;

(C) Have a door that opens directly to a hallway or common use room without passage through another bedroom or common bathroom;

(D) Be adequately ventilated, heated, and lighted with at least one window capable of being opened that meets the fire regulations described in subsection (k) of this section;

(E) Have at least 70 square feet of usable floor space for each individual or 120 square feet of usable floor space for two individuals; and

(F) Have no more than two persons per room.

(b) If an individual chooses to share a bedroom with another individual, the individuals must be afforded an opportunity to have a choice of roommates.

(c) Individuals must have the freedom to decorate and furnish his or her own bedroom as agreed to within the Residency Agreement.

(d) SINGLE ACTION LOCKS.

(A) An AFH-DD licensed on or after January 1, 2016 must have single action locks on the entrance doors to the bedroom for each individual, lockable by the individual, with only appropriate staff having keys.

(B) An AFH-DD licensed prior to January 1, 2016 must have single action locks on the entrance doors to the bedroom for each individual, lockable by the individual, with only appropriate staff having keys by September 1, 2018.

(C) Limitations may only be used when there is a health or safety risk, as described in OAR 411-360-0170 and 411-004-0040, and when a written informed consent is obtained.

(e) Providers, resident managers, or their family members must not sleep in areas designated as common use living areas or share bedrooms with individuals.

(f) There must be a bed for each individual. The bed must include a frame unless otherwise documented by an ISP team decision. The bed must include a clean and comfortable mattress, a waterproof mattress cover if an individual is incontinent, and a pillow.

(g) Each bedroom must have sufficient, separate, private dresser and closet space for the clothing and personal effects for each individual, including hygiene and grooming supplies. Individuals must be allowed to keep and use reasonable amounts of personal belongings and to have private, secure storage space.

(h) Drapes or shades for windows must be in good condition and allow privacy for individuals.

(i) Bedrooms must be on ground level for individuals who are non-ambulatory or have impaired mobility.

(j) Individual bedrooms must be in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with an intercom or audio monitor as approved by an ISP team.

(k) Bedrooms must have at least one window or exterior door that readily opens from the inside without special tools and that provides a clear opening of not less than 821 square inches (5.7 sq. ft.), with the least dimensions not less than 22 inches in height or 20 inches in width. Sill height must not be more than 44 inches from the floor level or there must be approved steps or other aids to window egress that may be used by individuals. Windows with a clear opening of not less than 5.0 square feet or 720 square inches with sill heights of 48 inches may be accepted when approved by the State Fire Marshal or the designee of the State Fire Marshal.

(5) MEALS.

(a) The provider must support the freedom of the resident to have access to his or her personal food at any time. Limitations may only be used when there is a health or safety risk, as described in OAR 411-360-0170 and OAR 411-004-0040, and when a written informed consent is obtained.

(b) Three nutritious meals and two snacks must be provided. Meals must be offered daily at times consistent with those in the community.

(A) Each meal must include food from the basic food groups according to the United States Department of Agriculture (USDA) and include fresh fruit and vegetables when in season unless otherwise specified in writing by a health care provider.

(B) Food preparation must include consideration of cultural and ethnic backgrounds, as well as, the food preferences of individuals.

(c) A schedule of meal times and menus for the coming week that consider individual preferences must be prepared and posted weekly in a location that is accessible to individuals and the families of the individuals. Menu substitutions in compliance with subsection (b) of this section are acceptable. If an individual misses or plans to miss a meal at a scheduled time, or requests an alternate meal time, an alternative meal must be made available. Individuals are not restricted to specific meal times and must be encouraged to choose when, where, and with whom to eat.

(d) The individual is responsible for the provision of food beyond the required three meals and two snacks.

(e) MODIFIED OR SPECIAL DIETS. For individuals with modified or special diets ordered by a physician or licensed health care provider, the provider must:

(A) Have menus for the current week that provide food and beverages that consider the preferences of the individual and are appropriate to the modified or special diet; and

(B) Maintain documentation that identifies how modified or special diets are prepared and served to individuals.

(f) Adequate storage must be available to maintain food at a proper temperature, including a properly working refrigerator. Food storage and preparation areas must be such that food is protected from dirt and contamination and free from food that is spoiled or expired.

(g) Meals must be prepared and served in the AFH-DD where individuals reside. Payment for meals eaten away from the AFH-DD for the convenience of the provider (e.g. restaurants, senior meal sites) is the responsibility of the provider. Meals and snacks as part of an individual recreational outing are the responsibility of the individual.

(h) Household utensils, dishes, and glassware must be washed in hot soapy water, rinsed, and stored to prevent contamination.

(i) Food storage and preparation areas and equipment must be clean, free of objectionable odors, and in good repair.

(j) Home-canned foods must be processed according to the guidelines of the Oregon State University Extension Service. Freezing is the most acceptable method of food preservation. Milk must be pasteurized.

(6) TELEPHONE.

(a) A telephone must be provided in the AFH-DD that is available and accessible for the use of the individuals for incoming and outgoing calls. Telephone lines must be unblocked to allow for access.

(b) Emergency telephone numbers for the following must be posted in close proximity to all phones utilized by the licensee, resident manager, individuals, and caregivers:

(A) Local CDDP;

(B) Police, fire, and medical if not served by 911;

(C) The provider if the provider does not reside in the AFH-DD;

(D) Emergency physician; and

(E) Additional persons to be contacted in the case of an emergency.

(c) Telephone numbers for making complaints or a report of alleged abuse to the Department, the local CDDP, and Disability Rights Oregon must also be posted.

(d) In all cases, a telephone must be accessible to individuals for outgoing calls 24 hours a day.

(e) AFH-DD telephone numbers must be listed in the local telephone directory.

(f) The licensee must notify the Department, individuals, and as applicable the families, legal representatives, and service coordinators of the individuals of any change in the AFH-DDs telephone number within 24 hours of the change.

(7) SAFETY.

(a) Buildings must meet all applicable state and local building, mechanical, and housing codes for fire and life safety. The AFH-DD may be inspected for fire safety by the Office of the State Fire Marshal at the request of the Department using the standards in these rules as appropriate.

(b) Heating in accordance with the specifications of the manufacturer and electrical equipment, including wood stoves, must be installed in accordance with all applicable fire and life safety codes. Such equipment must be used and maintained properly and be in good repair.

(A) Providers who do not have a permit verifying proper installation of an existing wood stove must have the wood stove inspected by a qualified inspector, Certified Oregon Chimney Sweep Association member, or Oregon Hearth Products Association member and follow the recommended maintenance schedule.

(B) Fireplaces must have protective glass screens or metal mesh curtains attached to the top and bottom of the fireplace.

(C) The installation of a non-combustible heat resistant safety barrier may be required to be installed 36 inches around wood stoves to prevent individuals with ambulation or confusion problems from coming in contact with the stove.

(D) Un-vented portable oil, gas, or kerosene heaters are prohibited. Sealed electric transfer heaters or electric space heaters with tip-over shut-off capability may be used when approved by the authority having jurisdiction.

(c) Extension cord wiring and multi-plug adaptors must not be used in place of permanent wiring. UL-approved, re-locatable power tabs (RPTs) with circuit breaker protection are permitted for indoor use only and must be installed and used in accordance with the instructions of the manufacturer. If RPTs are used, the RPTs must be directly connected to an electrical outlet, never connected to another RPT (known as daisy-chaining or piggy-backing), and never connected to an extension cord.

(d) All exit doors and interior doors used for exit purposes must have simple hardware that cannot be locked against exit and must have an obvious method of single action operation. Hasps, sliding bolts, hooks and eyes, and double key deadbolts are not permitted. Homes with one or more individuals who have impaired judgment and are known to wander away from their place of residence must have a functional and activated alarm system to alert a caregiver of an unsupervised exit by the individual.

(e) CARBON MONOXIDE ALARMS. Carbon monoxide alarms must be listed as complying with ANSI/UL 2034 and must be installed and maintained in accordance with the instructions of the manufacturer. Carbon monoxide alarms must be installed within 15 feet of each bedroom at the height recommended by the manufacturer.

(A) Carbon monoxide alarms may be hard wired, plug-in, or battery operated. Hard wired and plug-in alarms must be equipped with battery back-up. Battery operated alarms must be equipped with a device that warns of a low battery.

(B) Bedrooms used by hearing-impaired occupants who may not hear the sound of a regular carbon monoxide alarm must be equipped with an additional carbon monoxide alarm that has visual or vibrating capacity.

(f) SMOKE ALARMS. Smoke alarms must be installed in accordance with the instructions of the manufacturer in each bedroom, hallways or access areas that adjoin bedrooms, the family room or main living area where occupants congregate, laundry rooms, office rooms, and basements. In addition, smoke alarms must be installed at the top of all stairways in multi-level homes.

(A) Ceiling placement of smoke alarms is recommended. If wall mounted, smoke alarms must be between 6 inches and 12 inches from the ceiling and not within 12 inches of a corner.

(B) Smoke alarms must be equipped with a device that warns of low battery when battery operated or with a battery back-up if hard wired.

(C) When activated, smoke alarms must be audible in all bedrooms.

(D) Bedrooms used by hearing-impaired occupants who may not hear the sound of a regular smoke alarm must be equipped with an additional smoke alarm that has visual or vibrating capacity.

(g) All carbon monoxide alarms and smoke alarms must contain a sounding device or be interconnected to other alarms to provide, when activated, an alarm that is audible in all bedrooms. The alarms must be loud enough to wake occupants when all bedroom doors are closed.

(h) The licensee must test all carbon monoxide alarms and smoke alarms in accordance with the instructions of the manufacturer at least monthly (per NFPA 72). Testing must be documented in the AFH-DD records.

(i) FIRE EXTINGUISHERS. At least one 2A-10BC rated fire extinguisher must be in a visible and readily accessible location on each floor, including basements. Fire extinguishers must be inspected at least once a year by a qualified person that is well versed in fire extinguisher maintenance. All recharging and hydrostatic testing must be completed by a qualified agency properly trained and equipped for this purpose and documentation must be maintained in the AFH-DD records.

(j) The licensee must maintain carbon monoxide alarms, smoke alarms, and fire extinguishers in functional condition. If there are more than two violations in maintaining battery operated alarms in working condition, the Department may require the licensee to hard wire the alarms into the electrical system.

(8) EMERGENCY PROCEDURES AND PLANNING.

(a) EVACUATION DRILLS.

(A) The provider must conduct unannounced evacuation drills when individuals are present, once every quarter, with at least one drill per year occurring during the hours of sleep. Drills must occur at different times of the day, evening, and night, with exit routes being varied based on the location of a simulated fire. All occupants must participate in the evacuation drills.

(B) Written documentation must be made at the time of the drill and kept by the provider for at least two years following the drill. Evacuation drill documentation must include:

(i) The date and time of the drill or simulated drill;

(ii) The location of the simulated fire and exit route;

(iii) The last names of all individuals, the provider, caregivers, and all other occupants present on the premises at the time of the drill;

(iv) The type of evacuation assistance provided by the provider to individuals;

(v) The amount of time required by each individual to evacuate; and

(vi) The signature of the provider or caregiver conducting the drill.

(b) The provider must document that, within 24 hours of arrival, each new individual receives an orientation to basic safety and is shown how to respond to a fire and carbon monoxide alarm and how to exit from the AFH-DD in an emergency.

(c) The provider must demonstrate the ability to evacuate all individuals from the AFH-DD within three minutes. If there are problems in demonstrating this evacuation time, the Department may apply conditions to the license that include, but are not limited to, reduction of individuals under care, additional staffing, increased fire protection, or revocation of the license.

(d) The provider must provide, post, and keep up to date, a floor plan on each floor.

(A) The floor plan must contain:

(i) Room sizes;

(ii) The location of the bed for each individual;

(iii) Windows;

(iv) Exit doors;

(v) The sleeping rooms for the resident manager or provider;

(vi) Smoke and carbon monoxide alarms;

(vii) Fire extinguishers;

(viii) Escape routes; and

(ix) Wheelchair ramps.

(B) The floor plan must be updated to reflect any change and a copy of the updated floor plan must be submitted to the Department.

(e) There must be at least one plug-in rechargeable flashlight available for emergency lighting in a readily accessible area on each floor, including the basement.

(f) If an individual accesses the community independently, the provider must provide the individual information about appropriate steps to take in an emergency, such as emergency contact telephone numbers, contacting police or fire personnel, or other strategies to obtain assistance.

(g) WRITTEN EMERGENCY PLAN. Providers must develop, maintain, update, and implement a written Emergency Plan for the protection of all the individuals in the event of an emergency or disaster. The Emergency Plan must:

(A) Be practiced at least annually. The Emergency Plan practice may consist of a walk-through of the duties or a discussion exercise dealing with a hypothetical event, commonly known as a tabletop exercise;

(B) Consider the needs of the individuals being served and address all natural and human-caused events identified as a significant risk for the AFH-DD, such as a pandemic or an earthquake;

(C) Include provisions and sufficient supplies, such as sanitation and food supplies, to shelter in place, when unable to relocate, for at least three days under the following conditions:

(i) Extended utility outage;

(ii) No running water;

(iii) Inability to replace food supplies; and

(iv) Caregivers unable to report as scheduled.

(D) Include provisions for evacuation and relocation that Identifies:

(i) The duties of caregivers during evacuation, transporting, and housing of individuals including instructions to caregivers to notify the Department and local CDDP of the plan to evacuate or the evacuation of the AFH-DD as soon as the emergency or disaster reasonably allows;

(ii) The method and source of transportation;

(iii) Planned relocation sites that are reasonably anticipated to meet the needs of the individuals in the AFH-DD;

(iv) A method that provides persons unknown to the individual the ability to identify each individual by name, and to identify the name of the supporting provider for the individual; and

(v) A method for tracking and reporting to the Department and the local CDDP the physical location of each individual until a different entity resumes responsibility for the individual.

(E) Address the needs of the individuals including provisions to provide:

(i) Immediate and continued access to medical treatment with the evacuation of the individual summary sheet and the emergency information identified in OAR 411-360-0170, and other information necessary to obtain care, treatment, food, and fluids for individuals;

(ii) Continued access to life sustaining pharmaceuticals, medical supplies, and equipment during and after an evacuation and relocation;

(iii) Behavior support needs anticipated during an emergency; and

(iv) Adequate staffing to meet the life-sustaining and safety needs of the individuals.

(F) Providers must instruct and provide training to all caregivers about the duties and responsibilities of the caregivers for implementing the Emergency Plan.

(i) Documentation of caregiver training must be kept on record by the provider.

(ii) The provider must re-evaluate the Emergency Plan at least annually or when there is a significant change in the AFH-DD.

(G) Applicable parts of the Emergency Plan must coordinate with each applicable employment provider or day program provider to address the possibility of an emergency or disaster during day time hours.

(9) SPECIAL HAZARDS.

(a) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers or safety containers, and secured to prevent tampering by individuals and vandals.

(b) Oxygen and other gas cylinders in service or in storage must be adequately secured to prevent cylinders from falling or being knocked over. No smoking signs must be visibly posted where oxygen or other gas cylinders are present. Oxygen and other gas cylinders may not be used or stored in rooms where a wood stove, fireplace, or open flames are located.

(c) To protect the safety of an individual in an AFH-DD, the provider must store hunting equipment and weapons in a safe and secure manner inaccessible to the individuals in the AFH-DD. Ammunition must be secured in a locked area separate from the firearms.

(d) For AFH-DDs with one or more employees, smoking regulations in compliance with the Indoor Clean Air Act must be adopted to allow smoking only in outdoor designated areas. Signs must be posted prohibiting smoking in the workplace per OAR 333-015-0040.

(A) Designated smoking areas must be at least 10 feet from any entrance, exit, window that opens, ventilation intake, or accessibility ramp.

(B) Smoking is prohibited in bedrooms.

(C) Smoking is prohibited in vehicles when individuals or employees occupy the vehicle.

(D) Ashtrays of noncombustible material and safe design must be provided in areas where smoking is permitted.

(e) Cleaning supplies, poisons, and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, food preparation and storage, dining areas, and medications and in a manner to prevent tampering by individuals.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, 443.790

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411-360-0140

Standards and Practices for Health Care

(1) INDIVIDUAL HEALTH CARE. An individual must receive care and services that supports and promotes the health and well-being of the individual as follows:

(a) The AFH-DD must ensure each individual has a primary physician or primary licensed health care provider whom the individual or the legal representative of the individual has chosen from among qualified providers.

(b) The AFH-DD must ensure each individual receives a medical evaluation by a licensed health care provider no less than every two years or as recommended by the licensed health care provider.

(c) The AFH-DD must monitor the health status and physical conditions of each individual and take action in a timely manner in response to identified changes or conditions that may lead to deterioration or harm.

(d) A written and signed order from a physician or licensed health care provider is required prior to the use or implementation of any of the following:

(A) Prescription medications;

(B) Non-prescription medications except over the counter topicals;

(C) Treatments other than basic first aid;

(D) Modified or special diets;

(E) Adaptive equipment; and

(F) Aids to physical functioning.

(e) The provider must implement the order of a physician or licensed health care provider.

(f) Injections may be:

(A) Self-administered by the individual; or

(B) Administered by:

(i) A relative of the individual;

(ii) A currently licensed registered nurse;

(iii) A licensed practical nurse under registered nurse supervision; or

(iv) The provider, resident manager, or substitute caregiver who has been trained and is monitored by a physician or delegated by a registered nurse in accordance with the rules of the Board of Nursing in OAR chapter 851, division 047. Documentation regarding the training or delegation must be maintained in the record for the individual.

(2) REQUIRED DOCUMENTATION.

(a) A provider must maintain and keep current records on each individual to aid physicians, licensed health care providers, the CDDP, and the Department in understanding the medical history of the individual. Such documentation must include:

(A) A list of known health conditions, medical diagnoses, any known allergies, immunizations, Hepatitis B status, previous TB tests, incidents or injuries affecting the health, safety, or emotional well-being of the individual, and history of emotional or mental health status that may be pertinent to current care and services;

(B) A record of visits and appointments to licensed health care providers that includes documentation of the consultation, any treatment provided, and any follow-up reports provided to the provider;

(C) A record of known hospitalizations and surgeries;

(D) Current signed orders for all medications, treatments, therapies, special diets, and adaptive equipment;

(E) Medication administration records (MARs);

(F) Documentation of the consent from the legal representative of the individual for medical treatment that is not routine, including surgery and anesthesia; and

(G) Copies of previous mental health assessments and assessment updates, including multi-axial DSM diagnosis, treatment recommendations, and progress records for mental health treatment services.

(b) When requested, copies of medical records and MARs must be provided to the legal representative, Department case manager, or services coordinator.

(3) MEDICATION PROCUREMENT AND STORAGE. All medications must be:

(a) Kept in the original containers;

(b) Labeled by the dispensing pharmacy, product manufacturer, or physician, as specified by the written order of a physician or licensed health care provider; and

(c) Kept in a secured, locked container and stored as indicated by the product manufacturer.

(4) MEDICATION ADMINISTRATION.

(a) All medications and treatments must be recorded on an individualized MAR. The MAR must include:

(A) The name of the individual;

(B) A transcription of the written order of the physician or licensed health care provider including the brand or generic name of the medication, prescribed dosage, frequency, and method of administration;

(C) For over the counter topical medications without a written order from a physician or licensed health care provider, a transcription of the printed instructions from the topical medication package;

(D) Times and dates of administration or self-administration of the medication;

(E) Signature of the person administering the medication or the person monitoring the self-administration of the medication;

(F) Method of administration;

(G) An explanation of why a PRN (as needed) medication was administered;

(H) Documented effectiveness of any PRN (as needed) medication administration;

(I) An explanation of all medication administration or documentation irregularities; and

(J) Documentation of any known allergy or adverse drug reaction.

(b) Any errors in the MAR must be corrected with a circle of the error and the initials of the person making the correction.

(5) SELF-ADMINISTRATION OF MEDICATION.

(a) For individuals who independently self-administer medications, there must be a plan as determined by the ISP team for the periodic monitoring and review of the self-administration of medications.

(b) The AFH-DD must ensure that individuals able to self-administer medications keep the medications in a place unavailable to other individuals residing in the AFH-DD and store the medications as recommended by the product manufacturer.

(6) USE OF MEDICAL MARIJUANA.

(a) Prior to using medical marijuana in an AFH-DD, an individual must:

(A) Possess a valid OMMP registry card. A copy of the current OMMP registry card for the individual must be made available to the provider and maintained in the record for the individual;

(B) Provide a copy of the written statement by the physician that indicates medical marijuana may mitigate the symptoms of the qualifying condition of the individual and includes instructions for the use of medical marijuana;

(C) Be responsible for obtaining the marijuana from an OMMP approved third party grower who is not the provider, caregiver, resident manager, or any other occupant in or on the premises of the AFH-DD; and

(D) Sign an agreement that the individual understands that:

(i) Marijuana is not allowed to be grown by any person in or on the premises of the AFH-DD;

(ii) A participant in the OMMP may not possess more than one ounce of marijuana at any one time while in or on the premises of the AFH-DD;

(iii) Medical marijuana may only be administered by ingesting it with food and by a vaporizer. If assistance with administration is necessary, the individual must agree to arrange for a "designated primary caregiver". The designated primary caregiver must be authorized by the OMMP and identified on the OMMP registry card for the individual;

(iv) A provider, caregiver, resident manager, or any occupants of the AFH-DD cannot be designated as the OMMP-approved designated primary caregiver of the individual and identified on the OMMP registry card for the individual;

(v) A provider, caregiver, resident manager, or any occupants of the AFH-DD cannot assist with the preparation, administration, or delivery of medical marijuana;

(vi) The individual must maintain any equipment used to administer marijuana;

(vii) Marijuana must be kept in locked storage in the bedroom of the individual when not being administered;

(viii) The individual must immediately notify the OMMP of any change in status, such as a change in address, designated primary caregiver, or person responsible for the marijuana grow site. A copy of the updated OMMP registry card for the individual must be made available to the provider for the record of the individual; and

(ix) Failure to comply with Oregon laws, Oregon rules, or the Residency Agreement of the AFH-DD may result in additional action.

(b) An individual must comply with the Oregon Medical Marijuana Act, the rules for the OMMP in OAR chapter 333, division 008, these rules, and any other requirements for the OMMP.

(c) An individual must self-administer medical marijuana by ingesting the marijuana or inhaling the marijuana with a vaporizer. Smoking marijuana in or on the premises of the AFH-DD is prohibited. Marijuana must be administered privately in a room that is not shared with another person. The individual may not have visitors, other individuals, or any other person in this private space while self-administering the marijuana.

(d) An individual must designate a grower to provide the marijuana as necessary. The grower must not be the provider, resident manager, caregiver, or any occupant in or on the premises of the AFH-DD. The grower designated by the individual must be authorized by OMMP and identified on the OMMP registry card for the individual.

(A) The designated grower for individuals being served in the foster care system must accommodate the specific needs related to the dispensation and tracking of the controlled substance. Not more than 28 grams at a time may be stored on the property of the AFH-DD per card holder. The remainder of the OMMP card holder's marijuana must be stored at the site of the grower.

(B) Each 28 grams, as needed, must be packaged in an airtight container clearly dated and labeled as to the total amount in grams with the name of the OMMP card holder. The container must be stored in a locked cabinet as is done with all controlled medications. Each administration must be tracked on the individual's MAR as to dosage in grams as weighed on a scale, date, and time of day.

(e) A provider, caregiver, resident manager, or any other occupants in or on the premises of the AFH-DD must not prepare or in any way assist with the administration or procurement of an individual's marijuana. The provider must monitor the individual's usage of medical marijuana to ensure safety and to document that the individual's use of medical marijuana is in compliance with the physician's instructions for using marijuana as documented in the ISP or Service Agreement.

(f) If a provider, resident manager, or caregiver also has an OMMP card for medical purposes, a substitute caregiver must be available to support the individuals when the provider, resident manager, or caregiver is under the influence of the medical marijuana. Any OMMP card holder in or on the premises of the AFH-DD must not smoke marijuana in or on the premises of the AFH-DD but may ingest the marijuana or inhale the marijuana with a vaporizer.

(7) PSYCHOTROPIC MEDICATIONS.

(a) Psychotropic medications and medications for behavior must be:

(A) Prescribed by a physician or licensed health care provider through a written order; and

(B) Monitored by the prescribing physician or licensed health care provider, ISP team, and provider for desired responses and adverse consequences.

(b) A provider, resident manager, or any caregiver may not discontinue, change, or otherwise alter the prescribed administration of a psychotropic medication for an individual without direction from a physician or licensed health care provider.

(c) A provider, resident manager, or any caregiver may not use alternative medications intended to alter or affect mood or behavior, such as herbals or homeopathic remedies, without direction and supervision of a physician or licensed health care provider.

(d) PRN (as needed) psychotropic medication orders are not allowed.

(e) PSYCHOTROPIC MEDICATIONS FOR YOUNG ADULTS. A qualified mental health professional or a licensed health care provider must provide a mental health assessment prior to any young adult being prescribed one or more psychotropic medications or any antipsychotic medication.

(A) A mental health assessment is not required in the following situations:

(i) In case of urgent medical need;

(ii) For a change in the delivery system of the same medication;

(iii) For a change in medication within the same classification;

(iv) A one-time medication order given prior to a medical procedure; or

(v) An anti-epileptic medication prescribed for a seizure disorder.

(B) When a mental health assessment is required, the provider must notify and inform the following of the need for a mental health assessment:

(i) The legal guardian of the young adult, or the case manager of the Department when the Department is the legal guardian of the young adult; and

(ii) The services coordinator.

(C) The required mental health assessment:

(i) Must be completed within three months prior to the prescription of a psychotropic medication; or

(ii) May be an update of a prior mental health assessment that focuses on a new or acute problem.

(D) Information from the mental health assessment must be provided to a physician or licensed health care provider prior to the issuance of a prescription for a psychotropic medication.

(E) Within one business day after receiving a new prescription or knowledge of a new prescription for a psychotropic medication for the young adult, the provider must notify:

(i) The legal guardian of the young adult, or the case manager of the Department when the Department is the legal guardian of the young adult; and

(ii) The services coordinator.

(F) The notification described in subsection (E) of this section must contain:

(i) The name of the prescribing physician or licensed health care provider;

(ii) The name of the medication;

(iii) The dosage, any change of dosage, or suspension or discontinuation of the current psychotropic medication;

(iv) The dosage administration schedule prescribed; and

(v) The reason the medication was prescribed.

(G) The provider must get a written informed consent from one of the following prior to filling a prescription for any new psychotropic medication, except in case of urgent medical need:

(i) The legal guardian of the young adult; or

(ii) The Department when the Department is the legal guardian of the young adult.

(H) When a young adult has more than two prescriptions for psychotropic medications, an annual review of the psychotropic medications must occur by a physician, licensed health care provider, or a qualified mental health professional who has the authority to prescribe drugs, such as the Oregon Medicaid Drug Use Review Program.

(f) BALANCING TEST. When a psychotropic medication is first prescribed and annually thereafter, the provider must obtain a signed balanc-

ing test from the prescribing physician or licensed health care provider using the Balancing Test Form (form APD 4110), or by inserting the required form content into a form maintained by the provider.

(A) The provider must present the physician or licensed health care provider with a full and clear description of the behavior and symptoms to be addressed, as well as any side effects observed; and

(B) The provider must keep signed copies of the balancing test in the medical record for the individual for seven years.

(8) MEDICATION SAFEGUARDS.

(a) Safeguards to prevent adverse effects or medication reactions must be utilized and include:

(A) Whenever possible, obtaining all prescription medication for an individual, except samples provided by the physician or licensed health care provider, from a single pharmacy that maintains a medication profile for the individual;

(B) Maintaining information about each desired effects and side effects of the medication; and

(C) Ensuring that medications prescribed for one individual are not administered to, or self-administered by, another individual or caregiver.

(b) The record for an individual must include documentation of the reason when all medications are not provided through a single pharmacy.

(9) MEDICATION DISPOSAL. All unused, discontinued, outdated, recalled, and contaminated medications including over-the-counter medications may not be kept in the AFH-DD and must be disposed of within 10 days of expiration, discontinuation, or the knowledge of the provider of recall or contamination. A provider may contact the local Department of Environmental Quality waste management company in the area for instructions on proper disposal of medications. Disposal of all controlled medications must be documented and witnessed by at least one other person who is 18 years of age or older. A written record of the disposal of the medication must be maintained that includes documentation of:

(a) Date of disposal;

(b) Description of the medication, including dosage, strength, and amount being disposed;

(c) Name of the individual for whom the medication was prescribed;

(d) Reason for disposal;

(e) Method of disposal;

(f) Signature of the person disposing of the medication; and

(g) For controlled medications, the signature of a witness to the disposal.

(10) NURSING SERVICES.

(a) When nursing services are provided to an individual the provider must:

(A) Coordinate with the registered nurse and the ISP team to ensure that the nursing services being provided are sufficient to meet the health needs of the individual; and

(B) Implement the Nursing Service Plan, or appropriate portions therein, as agreed upon by the ISP team and registered nurse.

(b) COMMUNITY NURSING SERVICES. When community nursing services as described in OAR chapter 411, division 048 are provided to an individual, the foster care provider must:

(A) Coordinate with the registered nurse and the ISP team to ensure that the nursing services being provided are sufficient to meet the health needs of the individual; and

(B) Implement the Nursing Service Plan, or appropriate portions therein, as agreed upon by the ISP team and registered nurse.

(c) PRIVATE DUTY NURSING. Under OAR chapter 410, division 132, private duty nursing services may be allocated to a young adult aged 18 through 20 that resides in a foster home and meets the clinical criteria described in OAR 411-300-0120.

(A) A Nursing Service Plan must be present when Department funds are used for private duty nursing services. A services coordinator must authorize the provision of private duty nursing services as identified in an ISP.

(B) When private duty nursing services are provided to a young adult, the provider must:

(i) Coordinate with the registered nurse and the ISP team to ensure that the nursing services being provided are sufficient to meet the health needs of the young adult; and

(ii) Implement the Nursing Service Plan, or appropriate portions therein, as agreed upon by the ISP team and registered nurse.

(d) DIRECT NURSING SERVICES. Direct nursing services may be provided to individuals 21 years of age and over as described in OAR chapter 411, division 380.

(A) A Nursing Service Plan must be present when Department funds are used for direct nursing services. A services coordinator must authorize the provision of direct nursing services as identified in an ISP.

(B) When direct nursing services are provided to an individual the provider must:

(i) Coordinate with the registered nurse and the ISP team to ensure that the direct nursing services being provided are sufficient to meet the health needs of the individual; and

(ii) Implement the Nursing Service Plan, or appropriate portions therein, as agreed upon by the ISP team and registered nurse.

(C) An AFH-DD provider licensed by the Department may provide direct nursing services to individuals in the AFH-DD under the following conditions:

(i) The provider must meet the qualifications to provide direct nursing services described in OAR 411-380-0060;

(ii) More than one individual resides in the AFH-DD and requires direct nursing services;

(iii) The AFH-DD provider is the choice of the individual or the legal representative of the individual and is not for the convenience of the AFH-DD provider; and

(iv) The AFH-DD provider meets the requirements as an enrolled Medicaid Provider as described in OAR 411-380-0060 and has a separate and distinct Medicaid provider number.

(D) LIMITATIONS.

(i) While delivering a direct nursing service singularly to an eligible individual in the AFH-DD, the provider must assure the needs of other individuals in the home are met up to and including additional staffing, such as resident managers, substitute caregivers, or additional nurses in the home. Documentation must record staffing coverage; and

(ii) To assure the health and safety of individuals with medically complex conditions in an AFH-DD, an AFH-DD provider delivering direct nursing services in the licensed AFH-DD is limited to 40 total hours per week of direct nursing services.

(11) DELEGATION AND SUPERVISION OF NURSING TASKS. Nursing tasks must be delegated by a registered nurse to a provider, resident manager, and a substitute caregiver in accordance with the rules of the Oregon State Board of Nursing in OAR chapter 851, division 047.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, 443.790

Stats. Implemented: ORS 443.705-825

Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 34-2013, f. & cert. ef. 9-27-13; APD 29-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 47-2014, f. 12-26-14, cert. ef. 12-28-14; APD 30-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0160
Behavior Support

(1) A decision to develop a plan to alter the behavior of an individual must be made by the ISP team.

(a) A foster care provider must implement a Behavior Support Plan as developed by a qualified Behavior Consultant.

(b) If an ISP team authorizes development of a Behavior Support Plan or interaction guidelines, the provider must participate as requested by the Behavior Consultant.

(c) A Behavior Support Plan may not be altered by the provider.

(2) FUNCTIONAL BEHAVIORAL ASSESSMENT. Prior to the development of a formal Behavior Support Plan, as agreed to by the ISP team, a functional behavioral assessment must be conducted. The functional behavioral assessment must be based upon information provided by one or more persons who know the individual and include:

(a) A clear, measurable description of the behavior, including (as applicable) frequency, duration, and intensity of the behavior;

(b) A clear description and justification of the need to alter the behavior;

(c) An assessment of the meaning of the behavior, including the possibility that the behavior is one or more of the following:

(A) An effort to communicate;

(B) The result of a medical condition;

(C) The result of a psychiatric condition; or

(D) The result of environmental causes or other factors.

(d) A description of the context in which the behavior occurs; and

(e) A description of what currently maintains the behavior.

(3) BEHAVIOR SUPPORT PLAN.

(a) A Behavior Support Plan must include:

(A) An individualized summary of the needs, preferences, and relationships of the individual;

(B) A summary of the function of the behavior (as derived from the functional behavioral assessment);

(C) Strategies that are related to the function of the behavior and are expected to be effective in reducing challenging behaviors;

(D) Prevention strategies, including environmental modifications and arrangements;

(E) Early warning signals or predictors that may indicate a potential behavioral episode and a clearly defined plan of response;

(F) A general crisis response plan that is consistent with OIS;

(G) A plan to address post crisis issues;

(H) A procedure for evaluating the effectiveness of the Behavior Support Plan, including a method of collecting and reviewing data on frequency, duration, and intensity of the behavior;

(I) Specific instructions for caregivers who provide support to follow regarding the implementation of the Behavior Support Plan; and

(J) Positive behavior supports that includes the least intrusive intervention possible.

(b) A provider must maintain written evidence that an individual, the legal representative of the individual (if applicable), and the ISP team are aware of the development of a Behavior Support Plan and any objections or concerns must be documented.

(4) PROTECTIVE PHYSICAL INTERVENTION.

(a) The AFH-DD must only employ protective physical intervention techniques that are included in the current approved OIS curriculum or as approved by the OIS Steering Committee.

(b) Protective physical intervention techniques must only be applied:

(A) When the health and safety of an individual or others is at risk and the ISP team has authorized the procedures as documented by the decision of the ISP team, the procedures are documented in the ISP or Service Agreement, and the procedures are intended to lead to less restrictive intervention strategies;

(B) As an emergency measure, if absolutely necessary to protect the individual or others from immediate injury; or

(C) As a health related protection prescribed by a physician or licensed health care provider if absolutely necessary during the conduct of a specific medical or surgical procedure or for the protection of an individual during the time that a medical condition exists.

(c) TRAINING. Providers, resident managers, and substitute caregivers who support individuals who have behavior support needs that may require the application of protective physical intervention must be trained by an instructor certified in OIS when an ISP team has determined that there is probable cause for future application of protective physical intervention. Documentation verifying OIS training must be maintained in the personnel file of the provider, resident manager, and substitute caregiver.

(d) MODIFICATION OF TECHNIQUES. A provider must obtain the approval of the OIS Steering Committee for any modification of standard OIS protective physical intervention techniques. The request for modification of protective physical intervention techniques must be submitted to the OIS Steering Committee and must be approved in writing by the OIS Steering Committee prior to the implementation of the modification. The provider must maintain documentation of the approval of the OIS Steering Committee in the record for the individual.

(e) USE IN EMERGENCY SITUATIONS.

(A) Use of protective physical intervention techniques in emergency situations that are not part of an approved Behavior Support Plan must:

(i) Be reviewed by the provider, resident manager, or designee within one hour of application; and

(ii) Be used only until the individual is no longer an immediate threat to self or others.

(B) No later than one working day after the use of protective physical intervention techniques in an emergency situation, an incident report as described in subsection (f) of this section must be submitted to the services coordinator, personal agent (if applicable), or other Department designee.

(C) The ISP team must meet if an emergency protective physical intervention is used more than three times in a six-month period.

(f) INCIDENT REPORT.

(A) Any use of protective physical intervention must be documented in an incident report. The report must include:

(i) The name of the individual to whom the protective physical intervention was applied;

(ii) The date, type, and length of time the protective physical intervention was applied;

(iii) A description of the incident precipitating the need for the use of the protective physical intervention;

(iv) Documentation of any injury;

(v) The name and position of the caregiver applying the protective physical intervention;

(vi) The name and position of the caregivers witnessing the protective physical intervention; and

(vii) The name and position of the person conducting the review of the incident that includes the follow-up to be taken to prevent a recurrence of the incident.

(B) Within five working days of the incident, a copy of the incident report must be forwarded to the services coordinator or other Department designee (if applicable).

(C) If the protective physical intervention results in an injury, a copy of the incident report must be forwarded within one working day of the incident to the services coordinator or other Department designee (if applicable).

(D) A copy of an incident report not associated with a protective service investigation must be provided to the personal agent (if applicable) and the legal representative (if applicable) within the timeframes specified in this rule.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, & 443.790
Stats. Implemented: ORS 443.705 - 443.825
Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 34-2013, f. & cert. ef. 9-27-13; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0170
Documentation and Record Requirements

(1) INDIVIDUAL RECORDS. A record must be developed, kept current, and available on the premises of the AFH-DD for each individual admitted to the AFH-DD.

(a) The provider must maintain a summary sheet for each individual in the AFH-DD. The summary sheet must include:

(A) The name of the individual, current and previous address, date of entry into the AFH-DD, date of birth, gender, marital status, religious preference, preferred hospital, Medicaid prime and private insurance number (if applicable), and guardianship status; and

(B) The name, address, and telephone number of:

(i) The legal representative, family, advocate, or other significant person;

(ii) The primary physician or licensed health care provider and designated back up physician or licensed health care provider or clinic preferred by the individual;

(iii) The dentist preferred by the individual;

(iv) The day program or employer (if applicable);

(v) The services coordinator; and

(vi) Other representatives providing care and services to the individual.

(b) EMERGENCY INFORMATION. The provider must maintain emergency information for each individual receiving care and services in the AFH-DD in addition to the individual summary sheet identified in subsection (a) of this section. The emergency information must be kept current and must include:

(A) The name of the individual;

(B) The name, address, and telephone number of the provider;

(C) The address and telephone number of the AFH-DD where the individual resides if different from that of the provider;

(D) The physical description of the individual, which may include a picture of the individual with the date the picture was taken, and identification of:

(i) The race, gender, height, weight range, hair, and eye color of the individual; and

(ii) Any other identifying characteristics that may assist in identifying the individual, such as marks or scars, tattoos, or body piercings.

(E) Information on the abilities and characteristics of the individual including:

(i) How the individual communicates;

(ii) The language the individual uses and understands;

(iii) The ability of the individual to know how to take care of bodily functions; and

(iv) Any additional information that may assist a person not familiar with the individual to understand what the individual can do for him or herself.

(F) The health support needs of the individual including:

(i) Diagnosis;

(ii) Allergies or adverse drug reactions;

(iii) Health issues that a person needs to know when taking care of the individual;

(iv) Special dietary or nutritional needs, such as requirements around textures or consistency of foods and fluids;

(v) Food or fluid limitations due to allergies, diagnosis, or medications the individual is taking that may be an aspiration risk or other risk for the individual;

(vi) Additional special requirements the individual has related to eating or drinking, such as special positional needs or a specific way foods or fluids are given to the individual;

(vii) Physical limitations that may affect the ability of the individual to communicate, respond to instructions, or follow directions; and

(viii) Specialized equipment needed for mobility, positioning, or other health-related needs.

(G) The emotional and behavioral support needs of the individual including:

(i) Mental health or behavioral diagnosis and the behaviors displayed by the individual; and

(ii) Approaches to use when dealing with the individual to minimize emotional and physical outbursts.

(H) Any court ordered or guardian authorized contacts or limitations;

(I) The supervision requirements of the individual and why; and

(J) Any additional pertinent information the provider has that may assist in the care and services to support the individual if a natural or man-made disaster occurs.

(c) Individual records must be made available to representatives of the Department conducting inspections or investigations as well as to individuals to whom the information pertains, the legal representative of the individual, or other legally authorized people.

(d) Individual records must be kept by the provider for a period of at least three years. When an individual moves or an AFH-DD closes, copies of pertinent information must be transferred to the new place of residence for the individual.

(e) Providers must comply with ORS 179.505 in all other matters pertaining to confidential records and release of information.

(2) INDIVIDUAL ACCOUNT RECORDS. For those individuals not yet capable of managing money as determined by the ISP team or legal representative of the individual, the provider must prepare, maintain, and keep current a separate and accurate written record of all money received or disbursed on behalf of or by the individual.

(a) The account record must include:

(A) The date, amount, and source of income received;

(B) The date, amount, and purpose of funds disbursed; and

(C) The signature of the provider or caregiver making each entry.

(b) Purchases of $10.00 or more made on behalf of an individual must be documented by receipts unless an alternate amount is otherwise specified by the ISP team.

(c) Personal Incidental Funds (PIF) are to be used at the discretion of the individual for things, such as clothing, video games, and snacks (not part of daily diet) as addressed in the ISP for the individual.

(d) Each account record must include the disposition of the room and board fee that the individual pays to the provider at the beginning of each month.

(e) REIMBURSEMENT TO INDIVIDUAL. The provider must reimburse the individual any funds that are missing due to theft or mismanagement on the part of the provider, resident manager, or caregiver of the AFH-DD, or for any funds within the custody of the provider that are missing. Such reimbursement must be made within 10 business days of the verification that funds are missing.

(f) Financial records must be maintained for at least seven years.

(3) PERSONAL PROPERTY RECORD. A provider must prepare and maintain an accurate individual written record of personal property that has significant emotional or monetary value to each individual as determined by a documented ISP team or legal representative decision. The personal property record must include:

(a) The description and identifying number (if any):

(b) Date of inclusion in the record;

(c) Date and reason for removal from record;

(d) Signature of provider making each entry; and

(e) A signed and dated annual review of the personal property record for accuracy.

(4) INDIVIDUAL SUPPORT PLAN.

(a) The provider must collect and summarize the following information prior to an ISP meeting:

(A) One page profile reflecting, at a minimum, information gathered by the provider of the AFH-DD;

(B) Person-centered information reflecting, at a minimum, information gathered by the provider of the AFH-DD; and

(C) Information about known, identified serious risks.

(b) The following information must be developed by the provider and shared with the services coordinator and the individual, or if applicable the legal or designated representative of the individual, as directed by the Services Agreement.

(A) Implementation strategies, such as action plans, for desired outcomes or goals.

(B) Necessary protocols or plans that address health, behavioral, safety, and financial supports.

(C) A summary of the provider risk management strategies in place, including title of document, date, and where the document is located.

(D) A Nursing Service Plan, if applicable.

(E) Other documents required by the ISP team.

(c) When desired by the individual, the provider must participate in the ISP team meetings.

(d) A provider must agree in writing to implement the portion of the ISP for which the provider is responsible for implementing. Agreement may be recorded by a signature on the ISP or Service Agreement.

(e) The provider must maintain a copy of the ISP or Service Agreement provided the CDDP.

(f) The provider must maintain documentation of implementation of each support and services specified in subsections (b)(A) to (b)(E) of this section. This documentation must be kept current and be available for review by the individual, the legal representative of the individual, CDDP, and Department representatives.

(5) INDIVIDUALLY-BASED LIMITATIONS.

(a) For an initial or annual ISP authorized to begin on or after March 1, 2017, the provider must identify any individually-based limitations to the following freedoms:

(A) Support and freedom to access the individual's personal food at any time;

(B) Visitors of the individual's choosing at any time;

(C) A lock on the individual's bedroom, lockable by the individual;

(D) Choice of a roommate, if sharing a bedroom;

(E) Freedom to furnish and decorate the individual's bedroom as the individual chooses in accordance with the Residency Agreement; and

(F) Freedom and support to control the individual's schedule and activities.

(b) All individually-based limitations must be included in the ISP no later than February 28, 2018.

(c) An individually-based limitation to any freedom in subsection (a) of this section must be supported by a specific assessed need due to threats to the health and safety of the individual or others. The licensee must incorporate and document all applicable elements identified in OAR 411-004-0040, including:

(A) The specific and individualized assessed need justifying the individually-based limitation;

(B) The positive interventions and supports used prior to any individually-based limitation;

(C) Less intrusive methods that have been tried but did not work;

(D) A clear description of the condition that is directly proportionate to the specific assessed need;

(E) Regular reassessment and review to measure the ongoing effectiveness of the individually-based limitation;

(F) Established time limits for periodic review of the individually-based limitation to determine if the individually-based limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually;

(G) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the resident and the consent of the legal representative; and

(H) An assurance that the interventions and support do not cause harm to the individual.

(6) HOUSE RULES.

(a) House rules must be submitted and may be subject to review and approval by the Department or its designee prior to implementation and as changes occur.

(b) House rules must be posted in a conspicuous location in the AFH-DD that is accessible to individuals and visitors.

(c) House rules may not violate the rights of an individual as stated in ORS 430.210, ORS 443.739, OAR 411-318-0010, and described in section (11) of this rule.

(d) House rules may not be in conflict with these rules or the home and community-based services and settings rules in OAR chapter 411, division 004.

(e) A provider must review and provide a copy of the house rules to each individual, and as applicable the legal representative of the individual, at the time of entry and annually or as changes occur. The reviews must be documented by having the individual, or as applicable the legal representative of the individual, sign and date a copy of the house rules. A copy of the signed and dated house rules must be maintained in the record for the individual.

(7) RESIDENCY AGREEMENTS. The provider must maintain a Residency Agreement with all individuals as described in OAR 411-360-0055, and if applicable, specialized contracts with the Department, and tenancy agreements with room and board tenants.

(8) UNUSUAL INCIDENTS. A written report of all unusual incidents relating to an individual must be sent to the CDDP within five business days of the incident. The report must include how and when the incident occurred, who was involved, what action was taken by the provider or caregiver, the outcome to the individual, and what action is being taken to prevent the reoccurrence of the incident.

(9) GENERAL INFORMATION. The provider must maintain all other information or correspondence pertaining to the individual.

(10) MONTHLY PROGRESS NOTES. The provider must maintain and keep current monthly progress notes for each individual residing in the AFH-DD that include, at a minimum, the progress of the supports identified in the ISP or Service Agreement, any medical, behavioral, or safety issues, or any other events that are significant to the individual.

(11) BILL OF RIGHTS FOR INDIVIDUALS.

(a) As stated in ORS 443.739, each individual residing in an AFH-DD has the right to:

(A) Be treated as an adult, with respect and dignity.

(B) Be informed of all rights and all house rules.

(C) Be encouraged and assisted to exercise legal rights, including the right to vote.

(D) Be informed of his or her medical condition and the right to consent to or refuse treatment.

(E) Receive appropriate care and services, and prompt medical care as needed.

(F) A safe and secure environment.

(G) Be free from mental and physical abuse.

(H) Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner.

(I) Complete privacy when receiving treatment or personal care.

(J) Associate and communicate privately with any person the individual chooses.

(K) Send and receive personal mail unopened.

(L) Participate in activities of social, religious, and community groups.

(M) Have medical and personal information kept confidential.

(N) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space.

(O) Manage the individual's own money and financial affairs unless legally restricted.

(P) Be free from financial exploitation. The provider may not charge or ask for application fees or nonrefundable deposits and may not solicit, accept, or receive money or property from an individual other than the amount agreed to for services.

(Q) A written agreement regarding the services to be provided and the rate schedule to be charged. The provider must give 30 days' written notice before any change in the rates or the ownership of the home.

(R) Not to be transferred or moved out of the AFH-DD without 30 days' advance written notice and an opportunity for a hearing. A provider may transfer or discharge an individual only for medical reasons including a medical emergency described in ORS 443.738(11)(b), or for the welfare of the individual or other individuals residing in the AFH-DD, or for nonpayment.

(S) Be free of discrimination in regard to race, color, religion, gender, sexual orientation, or national origin.

(T) Make suggestions and complaints without fear of retaliation.

(U) Be encouraged and assisted in exercising all legal, civil, and human rights accorded to other citizens of the same age, except when limited by a court order.

(b) The provider must guarantee these rights and help individuals exercise them.

(c) The provider shall post a copy of the Bill of Rights in the entry or other equally prominent place in the AFH-DD. The Bill of Rights must include the name and phone number of the office to call in order to report a complaint.

(d) The provider must explain and provide a copy of the Bill of Rights along with a description of how to exercise these rights to each individual and the legal representative of the individual at the time of entry and document in the file for the individual that a copy of the Bill of Rights was provided.

(e) The provider must review the Bill of Rights with each individual and the legal representative of the individual annually or as changes occur.

(f) In addition to the rights described in subsection (1)(a) of this section, individuals receiving home and community-based services in residential and non-residential home and community-based settings have the right to home and community-based settings with the qualities described in OAR 411-004-0020(1).

(g) In addition to the rights described in subsections (1)(a) of this section, individuals receiving home and community-based services in provider owned, controlled, or operated residential settings have the right to provider owned, controlled, or operated residential settings with the qualities described in OAR 411-004-0020(2).

(12) AFH-DD records must be kept current and maintained by the provider and be available for inspection upon request.

(13) EMPLOYMENT RECORDS. AFH-DD records must include proof that the provider, resident manager, and any other caregivers have met the minimum qualifications as required by OAR 411-360-0110. The following documentation must be included in the AFH-DD record and made available for review upon request:

(a) Completed employment applications including the names, addresses, and telephone numbers of all caregivers employed by the provider. An application for employment in any capacity in an AFH-DD must include a question asking whether the person applying for employment has ever been found to have committed abuse;

(b) Proof that the provider has the approval from the Department for each subject individual, as defined in OAR 411-360-0020, to have contact with older adults, adults with disabilities, or adults with intellectual or developmental disabilities as a result of a background check as defined in OAR 407-007-0210;

(c) Proof of required training according to OAR 411-360-0120. Documentation must include the date of each training, subject matter, name of agency or organization providing the training, and number of training hours;

(d) A certificate to document completion of the Department's Basic Training Course for the provider, resident manager, and substitute caregivers;

(e) Proof of mandatory abuse report training for the provider, resident manager, and substitute caregivers;

(f) Proof of any additional training required for the specific classification of an AFH-DD or the provider, resident manager, and all caregivers; and

(g) Documentation of caregiver orientation to the AFH-DD, training of emergency procedures, training on the ISPs or Service Agreements for individuals, and training on behavior supports and the Nursing Service Plan (if applicable).

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, 443.790

Stats. Implemented: ORS 443.705-825

Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 25-2011(Temp), f. & cert. ef. 12-1-11 thru 5-29-12; SPD 29-2011(Temp), f. & cert. ef. 12-30-11 thru 5-29-12; SPD 5-2012, f. & cert. ef. 5-29-12; SPD 34-2013, f. & cert. ef. 9-27-13; APD 29-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 47-2014, f. 12-26-14, cert. ef. 12-28-14; APD 30-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0180
General Practices

The provider must:

(1) Post the license for the AFH-DD in a conspicuous location in the AFH-DD that is accessible to individuals and visitors;

(2) Cooperate with Department personnel in complaint investigation procedures, abuse investigations and protective services, planning for individual care and services, application procedures, and other necessary activities, and allow access of Department personnel to the AFH-DD, the individuals, and all records;

(3) Give care and services as appropriate to the age and condition of the individuals and as identified in the ISP or Service Agreement. The provider must be responsible for ensuring that the orders of physicians and health care providers are followed and that the physicians and health care

providers are informed of changes in health status and if the individual refuses care and services;

(4) In the absence of the provider, have a substitute caregiver on the premises that is capable of providing care and services as required by the age and condition of the individuals. An AFH-DD service recipient may not be a substitute caregiver. For provider absences beyond 72 hours, the CDDP must be notified of the name of the substitute caregiver and the plan of operation in the absence of the provider;

(5) A provider, resident manager, or caregiver must be present in the AFH-DD at all times individuals are present, unless specifically stated in an ISP or Service Agreement and granted as a variance by the Department;

(6) Allow individuals to exercise all civil and human rights accorded to other citizens;

(7) Not allow or tolerate physical, sexual, or emotional abuse or punishment, exploitation, or neglect of individuals;

(8) Provide care and services as agreed to in an ISP or Service Agreement;

(9) Keep information related to individuals confidential as required under ORS 179.505;

(10) Assure that the number of individuals requiring nursing care does not exceed the capability of the provider as determined by the Department;

(11) Not admit individuals without developmental or intellectual disabilities prior to the express permission of the Department. The provider must notify the CDDP prior to admitting an individual not referred for placement by the CDDP;

(12) Exercise reasonable precautions against any conditions that may threaten the health, safety, or welfare of individuals;

(13) Immediately notify the appropriate ISP team members (in particular the services coordinator and the legal representative) of any unusual incidents that include the following:

(a) Any significant change in medical status;

(b) An unexplained or unanticipated absence from the AFH-DD;

(c) Any alleged or actual abuse of the individual;

(d) Any major behavioral incident, accident, illness, or hospitalization;

(e) If the individual contacts or is contacted by the police; or

(f) The individual dies.

(14) Write an incident report for any unusual incident and forward a copy of the incident report to the CDDP within five working days of the incident unless the incident must be referred immediately for a protective services investigation. Copies of incident reports not involving a protective services investigation must be provided to the legal representative or personal agent, when applicable; and

(15) Notify the Department within 24 hours upon a change in the business address for electronic mail and the telephone number for the provider and the AFH-DD.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, & 443.790

Stats. Implemented: ORS 443.705 - 443.825

Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 5-2012, f. & cert. ef. 5-29-12; SPD 34-2013, f. & cert. ef. 9-27-13; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0190

Standards for Entry, Transfer, Community Living Supports, Exit, and Closure

(1) NON-DISCRIMINATION. An individual considered for Department-funded services may not be discriminated against because of race, color, creed, age, disability, gender, sexual orientation, 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. An individual who enters an AFH-DD is subject to eligibility as described in this section.

(a) To become a Department-funded resident of an AFH-DD, an individual must:

(A) Be an Oregon resident;

(B) Be receiving a Medicaid Title XIX (OHP) benefit package through OSIPM or OCCS medical program;

(C) Be determined eligible for developmental disabilities services by the CDDP of the county of origin as described in OAR 411-320-0080;

(D) Meet the level of care as defined in OAR 411-320-0020; and

(E) Be an individual who is not receiving other Department-funded in-home or other funded comprehensive residential services.

(b) Individuals receiving Medicaid OHP under OCCS medical coverage for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(A) The transfer of assets as set forth in OAR 461-140-0210 to 461-140-0300; and

(B) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(3) ENTRY. All individuals considered for entry into the AFH-DD must:

(a) Be referred by the CDDP or have prior written approval of the CDDP or Department if the services for the individual are paid for by the Department; or

(b) Be placed with the agreement of the CDDP if the individual is either private pay or not eligible for developmental disability services.

(4) ENTRY.

(a) ENTRY MEETING. A provider must participate in an entry meeting prior to the individual moving in to the home.

(b) At the time of a referral from the CDDP, a provider must demonstrate efforts to acquire the following individual information from the referring CDDP:

(A) A copy of the eligibility determination document;

(B) A statement indicating the safety skills, including the ability of the individual 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 any behavioral challenges, including supervision and support needs;

(D) A medical history and information on health care supports that includes (when available):

(i) The results of the most recent physical exam;

(ii) The 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) Copies of documents relating to the guardianship, conservatorship, health care representation, , power of attorney, or any legal restrictions on the rights of the individual (if applicable);

(G) A copy of the most recent Behavior Support Plan and assessment, ISP or Service Agreement, Nursing Service Plan, and Individualized Education Program (if applicable); and

(H) Copies of protocols, the risk tracking record, and any support documentation (if available).

(c) If an individual is being admitted from the family home of the individual and the information required in subsection (b) of this section is not available, the 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. The plan must include a written justification as to why the information is not available.

(5) The provider retains the right to deny the entry of any individual if the provider feels the support needs of the individual may not be met by the provider or for any other reason specifically prohibited by these rules.

(6) An AFH-DD may not be used as a site for foster care for children, adults from other agencies, or any other type of shelter or day care without the written approval of the Department.

(7) TRANSFERS.

(a) An individual may not be transferred by a provider to another AFH-DD or moved out of the AFH-DD without 30 days advance written notice to the individual, the legal representative of the individual, and the CDDP stating reasons for the transfer as provided in ORS 443.739(18) and OAR 411-088-0070, and the right of the individual to a hearing as provided in ORS 443.738(11)(c) and OAR 411-088-0080, except for a medical emergency or to protect the welfare of the individual or other individuals. Individuals may only be transferred by a provider for the following reasons:

(A) Behavior that poses a significant danger to the individual or others;

(B) Failure to make payment for care and services;

(C) The license for the AFH-DD has been suspended, revoked, not renewed, or the provider voluntarily surrendered the license;

(D) The care and service needs of the individual exceed the ability of the provider; or

(E) There is a mutual decision made by the individual, the legal representative of the individual, and the ISP team that a transfer is in the best interest of the individual and all ISP team members agree.

(b) Individuals who object to the transfer by the AFH-DD provider must be given the opportunity for a hearing as provided in ORS

443.738(11)(c) and OAR 411-088-0080. Participants may include the individual and at the request of the individual, the provider, a family member, and the CDDP. If a hearing is requested to appeal a transfer, the individual must continue to receive the same services until the appeal is resolved.

(8) COMMUNITY LIVING SUPPORTS.

(a) Community living supports may be provided to one or more individuals if the addition of the individual receiving community living supports in the AFH-DD does not cause the capacity of the AFH-DD as determined by OAR 411-360-0060 to exceed five. Relief care may not be provided for more than 14 consecutive days to a single individual without prior approval from the Department.

(b) The provider must have information sufficient to provide for the health and safety of an individual receiving community living supports that includes the following:

(A) Medications provided in a container labeled from a pharmacy or in the original container labeled from the manufacturer;

(B) A list of medications, administration times, and self-administration information as needed. Administration of medication must be documented on a MAR;

(C) Basic summary sheet for the individual that includes the following:

(i) The name of the physician or health care provider of the individual and the phone number for the physician or health care provider;

(ii) The name of the emergency contact person of the individual and the phone number for the emergency contact;

(iii) List of supports related to food and drink (textures, special diets, allergies, preferences);

(iv) List of supports related to health supports;

(v) List of supports related to safety, including ability to adjust water temperature; and

(vi) List of supports related to challenging behaviors.

(c) On the first relief care visit of an individual, the provider must practice and document a fire drill immediately upon the arrival of the individual. For subsequent relief care visits, the provider must review the fire evacuation procedures with the individual and document the review.

(d) No use of PRN (as needed) psychotropic medications is allowed.

(9) IMMEDIATE EXIT.

(a) An individual who was admitted on or after July 1, 2014 may be moved without advance notice if all of the following are met:

(A) The AFH-DD provider was not notified prior to the entry of the individual to the AFH-DD that the individual is on probation, parole, or post-prison supervision after being convicted of a sex crime;

(B) The AFH-DD provider learns that the individual is on probation, parole, or post-prison supervision after being convicted of a sex crime; and

(C) The individual presents a current risk of harm to another individual, staff, or visitor in the AFH-DD as evidenced by:

(i) Current or recent sexual inappropriateness, aggressive behavior of a sexual nature, or verbal threats of a sexual nature; or

(ii) Current communication from the State Board of Parole and Post-Prison Supervision, Department of Corrections, or community corrections agency parole or probation officer that the Static 99 score for the individual or other assessment indicates a probable sexual re-offense risk to others in the AFH-DD.

(b) Prior to the move, the AFH-DD provider must contact the Central Office of the Department by telephone to review the criteria in subsection (a) of this section. The Department shall respond within one business day of contact by the AFH-DD. The parole or probation officer of the Department of Corrections must be included in the review, if available. The Department shall advise the AFH-DD provider if rule criteria for immediate exit are not met. The Department shall assist in locating placement options.

(c) A written move-out notice must be completed on form number APD 0719DD. The form must be filled out in its entirety and a copy of the notice must be delivered in person to the individual or if applicable the legal representative of the individual. Where an individual lacks capacity and there is no legal representative, a copy of the notice to move-out must be immediately faxed to the State Long Term Care Ombudsman.

(d) Prior to the move, the AFH-DD licensee must orally review the notice and the right to object with the individual, or as applicable the legal representative of the individual, and determine if a hearing is requested. A request for hearing does not delay the exit. The AFH-DD must immediately telephone the Central Office of the Department when a hearing is requested. The hearing must be held within five business days of the exit of the individual. An informal conference may not be held prior to the hearing.

(10) EXIT.

(a) A provider may only exit an individual for valid reasons equivalent to those for transfers as described in section (7)(a) of this rule or for an immediate exit as described in section (9) of this rule.

(b) The provider must give at least 30 days written notice to an individual, the services coordinator, and the Department before termination of residency, unless an immediate exit as described in section (9) of this rule or where undue delay might jeopardize the health, safety, or well-being of the individual or others. If an individual requests a hearing to appeal an exit from an AFH-DD, the individual must receive the same services until the appeal is resolved. This does not apply to an immediate exit as described in section (9) of this rule.

(c) The provider must promptly notify the CDDP in writing if an individual gives notice or plans to leave the AFH-DD or if an individual abruptly leaves. An individual is not required to give notice to an AFH-DD provider if the individual chooses to exit the AFH-DD.

(11) EXIT MEETING. A provider must participate in an exit meeting before any decision to exit is made if required by the case management entity.

(12) CLOSURE. Providers must notify the Department and CDDP in writing prior to announcing a voluntary closure of the AFH-DD to individuals and the legal representatives of the individuals.

(a) The provider must give each individual, the legal representative of the individual, and the CDDP 30 days written notice of the planned closure, except in circumstances where undue delay might jeopardize the health, safety, or welfare of the individuals, provider, or caregivers.

(b) If a provider has more than one AFH-DD, the individuals may not be shifted from one AFH-DD to another AFH-DD without providing each individual, the legal representative of the individual, and the CDDP 30 days written notice of the planned closure, unless prior approval is given and agreement obtained from the individuals, the legal representative of the individuals, and the CDDP or when undue delay might jeopardize the health, safety, or well-being of the individuals, provider, or caregivers.

(c) A provider must return the AFH-DD license to the Department if the AFH-DD closes prior to the expiration of the license.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, 443.790

Stats. Implemented: ORS 443.705-825

Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 25-2011(Temp), f. & cert. ef. 12-1-11 thru 5-29-12; SPD 29-2011(Temp), f. & cert. ef. 12-30-11 thru 5-29-12; SPD 5-2012, f. & cert. ef. 5-29-12; SPD 34-2013, f. & cert. ef. 9-27-13; APD 29-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 47-2014, f. 12-26-14, cert. ef. 12-28-14; APD 30-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0200
Adjustment, Suspension or Termination of Payment

(1) The Department may adjust, suspend, or terminate payment to a provider when any of the following conditions occur:

(a) The license for the AFH-DD is revoked, suspended, or terminated;

(b) Upon finding that the provider is failing to deliver any care or service as agreed to in an ISP or Service Agreement;

(c) When funding, laws, regulations, or the priorities of the Department change such that funding is no longer available, redirected to other purposes, or reduced;

(d) The care and service needs of an individual change;

(e) An individual is absent for five or more consecutive days without providing notice to the provider;

(f) An individual is determined to be ineligible for services; or

(g) An individual moves, with or without notice, from the AFH-DD. The provider is paid only through the last night the individual slept in the AFH-DD.

(2) The Department is under no obligation to maintain the AFH-DD at its licensed capacity or to provide payments to potential providers.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, & 443.790

Stats. Implemented: ORS 443.705 - 443.825

Hist.: SPD 3-2005, f. 1-10-05, cert. ef 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 34-2013, f. & cert. ef. 9-27-13; APD 21-2016, f. & cert. ef. 6-29-16

411-360-0260
Civil Penalties

(1) A civil penalty of not less than $100 and not more than $250 per violation, except as otherwise provided in this rule, is imposed on a licensee for a general violation of these rules.

(2) A civil penalty of up to $500, unless otherwise required by law, is imposed for falsifying individual or AFH-DD records or causing another to falsify individual or AFH-DD records.

(3) A civil penalty of $250 is imposed on a licensee for failure to have either the provider, resident manager, or other qualified caregiver on duty 24 hours per day in the AFH-DD per ORS 443.725(3), unless permitted under OAR 411-360-0180(7).

(4) A civil penalty of $250 is imposed for dismantling or removing the battery from any required smoke alarm or failing to install any required smoke alarm.

(5) A civil penalty of not less than $250 and not more than $500, unless otherwise required by law, is imposed on a licensee who admits knowing that the care or service needs of an individual exceed the license classification of the AFH-DD if the admission places the individual or other individuals at grave risk of harm.

(6) Civil penalties of up to $1,000 per occurrence may be assessed for substantiated abuse.

(7) If the Department conducts an abuse investigation and the substantiated abuse resulted in the death, serious injury, rape, or sexual abuse of an individual, a civil penalty of not less than $2,500 is imposed for each violation.

(a) To impose the civil penalty in section (7) of this rule, the Department must establish that:

(A) The abuse arose from deliberate or other than accidental action or inaction;

(B) The conduct resulting in the abuse was likely to cause death, serious injury, rape, or sexual abuse of an individual; and

(C) The person with the substantiated finding of abuse had a duty of care and services toward the individual.

(b) For the purpose of the civil penalty in section (7) of this rule, the following definitions apply:

(A) "Serious injury" means a physical injury that creates a substantial risk of death or that causes serious disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.

(B) "Rape" means rape in the first, second, or third degree as described in ORS 163.355, 163.365, and 163.375.

(C) "Sexual abuse" means any form of nonconsensual sexual contact including, but not limited to, unwanted or inappropriate touching, sodomy, sexual coercion, sexually explicit photographing, or sexual harassment. The sexual contact must be in the form of any touching of the sexual or other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party.

(D) "Other than accidental" means failure on the part of the licensee, employees, agents, or volunteers for whose conduct licensee is responsible, to comply with applicable Oregon Administrative Rules.

(8) In addition to any other liability or penalty, the Department may impose a civil penalty for any of the following:

(a) Operating the AFH-DD without a license;

(b) The number of individuals exceeds the licensed capacity for the AFH-DD;

(c) The licensee fails to achieve satisfactory compliance with the requirements of these rules within the time specified or fails to maintain such compliance;

(d) The AFH-DD is unable to provide an adequate level of care and services to support individuals in the AFH-DD;

(e) There is retaliation or discrimination against an individual, family member, employee, or any other person for making a complaint against the AFH-DD;

(f) The licensee fails to cooperate with the Department, physician, registered nurse, or other health care provider in carrying out the ISP or Service Agreement for an individual;

(g) The licensee fails to obtain an approved background check from the Department on a subject individual as defined in OAR 411-360-0020 prior to the subject individual operating, working, training in, or residing in an AFH-DD;

(h) Violations are found on two consecutive inspections of an AFH-DD after a reasonable amount of time prescribed for elimination of the violations has passed; or

(i) Violations other than those involving the health, safety, or welfare of an individual if the licensee fails to correct the violation as required when a reasonable timeframe for correction was given.

(9) In imposing a civil penalty pursuant to this rule, except for a civil penalty imposed pursuant to section (7) of this rule, the following factors are considered by the Department:

(a) The past history of the licensee incurring a civil penalty in taking all feasible steps or procedures necessary or appropriate to correct any violation;

(b) Any prior violations of statutes or rules pertaining to AFH-DD;

(c) The economic and financial conditions of the licensee incurring the civil penalty; and

(d) The immediacy and extent to which the violation threatens or threatened the health, safety, and welfare of the individuals.

(10) The notice of civil penalty is delivered in person or sent by registered or certified mail and includes:

(a) A reference to the particular sections of the statute, rule, standard, or order involved;

(b) A short and plain statement of the matter asserted or charged;

(c) A statement of the amount of the civil penalty or penalties imposed; and

(d) A statement of the right of the licensee to request a contested case hearing.

(11) The licensee has10 calendar days after the receipt of the notice of civil penalty in which to make a written application for a contested case hearing before the Department. A final order by default is issued by the Department if a written request for a contested case hearing is not timely received.

(12) All contested case hearings are conducted pursuant to the applicable provisions of ORS chapter 183.

(13) Except as may be prohibited by state law, a civil penalty imposed under ORS 443.455 or 441.710 may be remitted or reduced upon such terms and conditions as the Director of the Department considers proper and consistent with individual health and safety.

(14) If a final order is not appealed, the amount of the civil penalty is payable within 10 days after the final order is entered. If the final order is appealed and is sustained, the amount of the civil penalty is payable within 10 days after the court decision. The final order, if not appealed or sustained on appeal, constitutes a judgment and may be filed in accordance with provisions of ORS Chapter 18. Execution may be issued upon the order in the same manner as execution upon a judgment of a court of record.

(15) A violation of any general order or final order pertaining to an AFH-DD issued by the Department is subject to a civil penalty in the amount of not less than $5 and not more than $500 for each and every violation.

(16) Judicial review of civil penalties imposed under ORS 441.710 is provided under ORS 183.480, except that the court may, in its discretion, reduce the amount of the penalty.

(17) All penalties recovered under ORS 443.455 and 441.710 to 441.740 are to be paid into the Quality Care Fund.

Stat. Auth.: ORS 409.050, 410.070, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.765, 443.767, 443.775, & 443.790

Stats. Implemented: ORS 443.705 - 443.825

Hist.: SPD 3-2005, f. 1-10-05, cert. ef. 2-1-05; SPD 13-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 5-2012, f. & cert. ef. 5-29-12; SPD 34-2013, f. & cert. ef. 9-27-13; APD 21-2016, f. & cert. ef. 6-29-16

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Rule Caption: ODDS: Employment Services for Individuals with Intellectual or Developmental Disabilities

Adm. Order No.: APD 22-2016

Filed with Sec. of State: 6-29-2016

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Notice Publication Date: 4-1-2016

Rules Amended: 411-345-0010, 411-345-0020, 411-345-0025, 411-345-0027, 411-345-0030, 411-345-0085, 411-345-0095, 411-345-0110, 411-345-0130, 411-345-0140, 411-345-0160, 411-345-0170, 411-345-0180, 411-345-0190, 411-345-0200, 411-345-0230, 411-345-0240, 411-345-0250, 411-345-0260, 411-345-0270

Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the rules in OAR chapter 411, division 345 for employment services for individuals with intellectual or developmental disabilities.

These rules are being amended to:

- Make permanent temporary changes that became effective on January 1, 2016;

- Remove general definitions included in OAR 411-317-0000;

- Incorporate the standards for home and community-based (HCB) services and settings and person-centered service planning adopted by the Department in OAR chapter 411, division 004 to implement the regulations and expectations of the U.S. Department of Health

and Human Services, Centers for Medicare and Medicaid Services (CMS);

- Incorporate the individual rights in OAR chapter 411, division 318 to ensure uniform standards related to individual rights across all types of entities involved in the delivery of developmental disabilities services;

- Ensure alignment with Executive Order 15-01 and OAR chapter 407, division 025 regarding integrated employment services to individuals with intellectual and developmental disabilities;

- Implement Oregon's Employment First Policy;

- Align with the terms of the Lane v. Brown settlement agreement;

- Move non-employment services to the new rules for community living supports in OAR chapter 411, division 450;

- Move case management requirements to the new rules for case management in OAR chapter 411, division 415;

- Require new provider organizations to be certified as agencies under OAR chapter 411, division 323 and endorsed to provide employment services under OAR chapter 411, division 345;

- Require existing providers certified under OAR chapter 411, division 340 to be certified under OAR chapter 411, division 323 as certification renews;

- Move the general provider enrollment requirements that are not specific to employment service providers to the rules in OAR chapter 411, division 370;

- Reflect current Department terminology and the restructuring of the rules relating to developmental disabilities services; and

- Perform minor grammar, punctuation, formatting, and housekeeping changes.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-345-0010
Statement of Purpose

(1) The rules in OAR chapter 411, division 345, effectuate Oregon's Employment First policy under which the employment of individuals with intellectual or developmental disabilities in competitive integrated employment is the highest priority over unemployment, segregated employment, or other non-work day activities.

(2) For individuals who successfully achieve the goal of competitive integrated employment, future person-centered service planning focuses on maintaining employment, maximizing the number of hours an individual works, consistent with his or her preferences and interests, and considering additional career or advancement opportunities.

(3) Employment services are considered and provided on an individualized basis using a person-centered approach based on informed choice and consistent with the philosophy of self-determination.

(4) These rules:

(a) Prescribe service standards and requirements for providers of home and community-based services in settings where employment services are provided;

(b) Prescribe the standards and procedures by which the Department endorses a provider agency to deliver employment services;

(c) Prescribe service eligibility requirements for individuals with intellectual or developmental disabilities to receive employment services; and

(d) Incorporate the provisions for home and community-based services and settings and person-centered service planning set forth in OAR chapter 411, division 004 to ensure individuals with intellectual or developmental disabilities receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving home and community-based services.

(5) Employment services are provided in accordance with these rules, Oregon's Employment First policy as described in the State of Oregon Executive Order No. 15-01, and OAR chapter 407, division 025 (Integrated Employment Services to Individuals with Intellectual and Developmental Disabilities).

Stat. Auth.: ORS 409.050, 427.007, 430.662
Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0000, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; 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 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 31-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0020
Definitions and Acronyms

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 345:

(1) "CDDP" means "Community Developmental Disabilities Program".

(2) "Competitive Integrated Employment" means work that is performed on a full-time or part-time basis (including self-employment):

(a) For which an individual:

(A) Is compensated at a rate that:

(i) Is not less than the higher of the rate specified in federal, state, or local minimum wage law, and also is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; or

(ii) In the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities, and who are self-employed in similar occupations or on similar tasks and who have similar training, experience, and skills; and

(B) Is eligible for the level of benefits provided to other employees.

(b) That is at a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and

(c) That, as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(3) "Customized Employment" means competitive integrated employment for an individual with a disability that is based on an individualized determination of the strengths, needs, and interests of the individual, is designed to meet the specific abilities of the individual and the business needs of the employer.

(4) "Discovery" is a time-limited comprehensive, person-centered, and community-based employment planning support service to better inform an individual seeking an individualized job in a competitive integrated employment setting and to create a Discovery Profile. Discovery includes a series of work or volunteer related activities to inform the individual and the job developer about the strengths, interests, abilities, skills, experiences, and support needs of the individual, as well as identify the conditions and employment settings in which the individual will be successful. Discovery is also an opportunity for the individual to begin active pursuit of competitive integrated employment.

(5) "Discovery Profile" is a comprehensive and person-centered report produced as an outcome of discovery, representing an individual and providing information to better inform employment service planning and job development activities. The Discovery Profile includes information about the strengths, interests, abilities, skills, experiences, and support needs of the individual, as well as information about conditions and employment settings for the success of the individual.

(6) "Employment Path Services" means services to provide learning and work experiences, including volunteer opportunities, for an individual to develop general, non-job-task-specific, strengths and skills that contribute to employability in an individual job in a competitive integrated employment setting in the general workforce.

(7) "Employment Professional" means an employee of a provider agency or an independent provider who has the qualifications and training to provide employment services under these rules, including individual employment support, small group employment support, discovery, or employment path services.

(8) "Endorsement" means the authorization to provide program services issued by the Department to a certified provider agency that has met the qualification criteria outlined in these rules, the corresponding program rules, and the rules in OAR chapter 411, division 323.

(9) "Evidence-Based Practices" means well-defined best practices, which have been demonstrated to be effective by multiple peer-reviewed research studies that are specific to the relevant population or subset of that population.

(10) "Executive Director" means the person designated by a board of directors or corporate owner of a provider agency who is responsible for the administration of agency provided employment services.

(11) "Functional Needs Assessment":

(a) Means the comprehensive assessment or re-assessment that:

(A) Documents physical, mental, and social functioning;

(B) Identifies risk factors and support needs; and

(C) Determines the service level.

(b) The functional needs assessment may be the Adult Needs Assessment (ANA), Child Needs Assessment, Support Needs Assessment Profile (SNAP), or Supports Intensity Scale (SIS).

(A) The Department incorporates Version C of the ANA and CNA into these rules by this reference. The ANA and CNA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm.

(B) The Department incorporates the SNAP into these rules by this reference. The SNAP is maintained by the Department at https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/PROVIDERS-PARTNERS/Pages/rebar-assessments.aspx.

(C) The Department incorporates the SIS into these rules by this reference. The SIS is maintained at http://aaidd.org/sis#.VvwgeaPn_Dc.

(c) A printed copy of a blank functional needs assessment may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

(12) "Individual Employment Support" means job coaching or job development services to obtain, maintain, or advance in an individual job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment.

(13) "ISP" means "Individual Support Plan".

(14) "Job Coaching" means support for an individual to maintain or advance in an individual job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment.

(15) "Job Development" means support for an individual to obtain an individual job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment.

(16) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(17) "PRN" means the administration of medication to an individual on an 'as needed' basis (pro re nata).

(18) "Small Group Employment Support" means services and training activities provided in regular business, industry, and community settings for groups of two to eight individuals with disabilities. Small group employment support is provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.

(19) "These Rules" mean the rules in OAR chapter 411, division 345.

(20) "Vocational Assessment" means an assessment administered to provide employment related information essential to the development of, or revision of, the employment related planning documents for an individual.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 31-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0025
Services Provided

(1) The delivery of employment services provided under these rules presumes all individuals eligible for services can succeed in a job and career in an integrated employment setting in the general workforce and earn minimum wage or better.

(2) Employment is the preferred activity for individuals receiving services under these rules. Competitive integrated employment is the highest priority over unemployment, segregated or sheltered employment, small group employment support, or non-work day activities.

(3) Employment services must be individually planned based on person-centered planning principles. Consistent with the person-centered approach to these services, individuals accessing employment services under these rules must be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to employment or career advancement.

(4) All employment services have an optimal and expected outcome of sustained paid employment at the maximum number of hours, consistent with individual preferences, and work experience leading to further career development, maximizing hours, and competitive integrated employment for which an individual is compensated at or above minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(5) A provider initially certified and endorsed on or after January 1, 2016 must meet the requirements in OAR chapter 411, division 004 prior to being certified and endorsed. A provider certified and endorsed prior to January 1, 2016 must make measurable progress toward compliance with the rules in OAR chapter 411, division 004 and be in full compliance by September 1, 2018

(6) Employment services are provided under these rules in accordance with the State of Oregon Executive Order No. 15-01 and OAR chapter 407, division 025 (Integrated Employment Services to Individuals with Intellectual and Developmental Disabilities).

(7) Employment services must be evidence-based where evidence-based practices have been identified.

(8) Employment services must be:

(a) Offered to eligible individuals in accordance with the exit, entry, and transfer requirements described in OAR 411-345-0140;

(b) Provided to eligible individuals under the authorization of an ISP and Career Development Plan in accordance with OAR 411-345-0160;

(c) Offered in accordance with these rules;

(d) Provided in a non-residential setting, unless an individual is operating a home-based business;

(e) Provided in the most integrated employment setting appropriate to the needs of an individual, and consistent with the choice of the individual regarding services, providers, and goals; and

(f) Designed to:

(A) Increase independence, integration, and regular engagement in income producing work, preferably competitive integrated employment, by an individual that is measured through improvements in income level, employment status, or job advancement, or engagement by an individual with an intellectual or developmental disability in work contributing to a household or community;

(B) Promote integration into the workforce and workplace;

(C) Promote interaction with people without disabilities; and

(D) Support successful employment outcomes consistent with personal and career goals.

(9) Employment services do not include:

(a) Services available to an individual under Vocational Rehabilitation and Other Services, 29 U.S.C. § 701-796l, as amended;

(b) Services available to an individual under the Individuals with Disabilities Education Act, 20 U.S.C §1400, as amended;

(c) Vocational assessments in a sheltered workshop; or

(d) Services used for support to work in a sheltered workshop setting for individuals who did not enter or use services for support in a sheltered workshop setting on or before June 30, 2015.

(10) Employment services include the following:

(a) SUPPORTED EMPLOYMENT.

(A) INDIVIDUAL EMPLOYMENT SUPPORT:

(i) JOB COACHING — Support to maintain or advance in an individualized job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment. This also includes support for maximizing hours, pay, benefits, and other opportunities for career advancement.

(I) Personal care or attendant care provided as an incidental part of job coaching is considered a component part of the employment service.

(II) Job coaching does not include support in volunteer work.

(III) Individuals utilizing job coaching must be compensated at a rate that is not less than the higher of the rate specified in federal, state, or local minimum wage law and also is not less than the customary rate and benefits paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills.

(IV) Direct and indirect job coaching support must be provided, at minimum, for the number of hours identified in an ISP or Service Agreement.

(V) Transportation provided within the course of job coaching is a component part of the employment service.

(ii) Job coaching support to maintain self-employment requires the following in addition to the requirements outlined under (i):

(I) Ongoing assistance, counseling, and guidance after a business has been launched.

(II) Support to maintain self-employment may not be provided to defray the operational expenses of the business.

(III) The self-employment must yield an income that is comparable to the income received by other people who are not individuals with disabilities, and who are self-employed in similar occupations or in similar tasks and who have similar training, experience, and skills.

(IV) Evidence of the self-employment must be documented and reviewed by the services coordinator or personal agent on an annual basis. Documentation may include, but is not limited to, business filings with the Secretary of State, tax records submitted to the Internal Revenue Service, and an annual business plan.

(iii) JOB DEVELOPMENT — Support to obtain an individual job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment.

(I) Personal care or attendant care provided as an incidental part of job development is considered a component part of the employment service.

(II) The job developed must provide compensation at a rate that is not less than the higher of the rate specified in federal, state, or local minimum wage law and also is not less than the customary rate and benefits paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills.

(III) The job developed must meet criteria established in a Career Development Plan or Individual Plan for Employment (IPE) including, but not limited to, criteria regarding the number of hours the individual shall work in the job. The Career Development Plan must document either a goal or discussion regarding opportunities for maximizing work hours and other career advancement opportunities. The recommended standard for planning job coaching and job development is the opportunity to work at least 20 hours per week. Individualized planning should ultimately be based on person-centered planning principles, including individual choice, preferences, and circumstances, and recognize that some individuals may choose to pursue working full time, part time, or another goal identified by the individual.

(IV) Job development may be authorized in the limited circumstances where the service is not available through Vocational Rehabilitation and the Department has approved authorization.

(V) Transportation provided within the course of job development is a component part of the employment service.

(B) SMALL GROUP EMPLOYMENT SUPPORT — Services and training activities in regular business, industry, and community settings.

(i) Small group employment support may be provided in groups of two to eight individuals.

(ii) Small group employment support must be provided in a manner that promotes integration into the work place and interaction with people without disabilities in those work places.

(iii) Small group employment support does not include vocational services provided in a provider owned, operated, or controlled setting, or a facility-based work setting.

(iv) Small group employment support does not include support in volunteer work.

(v) Individuals utilizing small group employment support must be compensated at a rate that is not less than the higher of the rate specified in federal, state, or local minimum wage law and also is not less than the customary rate and benefits paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills.

(vi) Personal care or attendant care provided as an incidental part of small group employment support is considered a component part of the employment service.

(vii) Transportation provided within the course of small group employment support is a component part of the employment service.

(b) DISCOVERY — A comprehensive and person-centered employment planning support service to better inform an individual seeking competitive integrated employment in the general workforce and develop a Discovery Profile.

(A) Discovery must include a series of work or volunteer related activities, completed in competitive integrated employment settings, to inform the individual and the job developer about the strengths, interests, abilities, skills, experiences, and support needs of the individual. Discovery must include analyzing detailed information from novel and past experiences in order to identify the conditions or integrated employment settings in which the individual shall be most successful.

(B) Discovery may include job and task analysis activities, assessment for use of assistive technology, job shadowing, informational interviewing, employment preparation, resume development, and volunteerism to identify transferable skills and job or career interests.

(C) Discovery must be completed within a three month period. A three month extension may be authorized if the individual and the services coordinator or personal agent determines there is a legitimate reason. Legitimate reasons may include, but are not limited to:

(i) The individual had a medical event that delayed completing discovery;

(ii) The individual had a medical event that significantly changed his or her strengths, interests, and abilities; or

(iii) An opportunity to participate in particular work trials or volunteer positions may only be scheduled outside of the three month period.

(D) Discovery must have an outcome of a Discovery Profile. The Discovery Profile must meet requirements established by the Department.

(E) Discovery most often results in a referral to vocational rehabilitation services.

(F) Personal care or attendant care provided as an incidental part of discovery is considered a component part of the employment service.

(G) Transportation provided within the course of discovery is a component part of the employment service.

(c) EMPLOYMENT PATH SERVICES — Support to obtain experience and develop general skills that contribute to employability in competitive integrated employment settings in the general workforce.

(A) Personal care or attendant care provided as an incidental part of employment path services is considered a component part of the employment service.

(B) Producing goods or services may be incidental to employment path services but the primary purpose must be to develop general employment skills that may be used in an individual integrated job.

(C) Employment path services are time-limited based on the ISP. These services are expected to occur over a defined period of time with specific outcomes to be achieved, as determined by the individual and his or her service and supports planning team through an ongoing person-centered planning process.

(i) Prior to beginning employment path services there must be measureable goals outlined in the Career Development Plan that support the intended outcomes of this service.

(ii) The measureable goals must include a timeline for achieving the goals as well as the frequency and duration for which progress towards achieving the goals are monitored by the services coordinator or personal agent during service monitoring as outlined in OAR chapter 411, division 415.

(D) Employment path services require that an individual have an employment-related goal in his or her ISP. The employment goal must be related to obtaining, maintaining, or advancing in competitive integrated employment, or, at minimum, exploring competitive integrated employment. General habilitation activities accessed through employment path services must be designed to support such employment goals.

(E) Transportation provided within the course of employment path services is a component part of the employment service.

(F) Consistent with setting requirements for home and community-based services, employment path services must be provided in an integrated setting that supports an individual's full access to the community and where individuals using these services gain experience working with the general public to the same or a similar degree as individuals who do not have a disability and do not use home and community-based services.

(i) A provider agency initially certified or endorsed by the Department on or after January 1, 2016, must provide this service in settings that meet this requirement.

(ii) An existing provider agency certified and endorsed prior to January 1, 2016, must make measurable progress toward compliance with this requirement, consistent with a Department approved transition plan, and be in full compliance with this requirement by September 30, 2018.

(G) Employment path services are a facility-based service if delivered at a fixed site where the supported individual has few or no opportunities to interact with people who do not have a disability except for paid staff. Facility-based employment services under this definition are permissible until September 30, 2018.

(H) Employment path services are the only service that may be used for support in a sheltered workshop setting. Effective July 1, 2015, no service may be authorized in a sheltered workshop setting for any individual who has not already entered or used services for support to work in a sheltered workshop.

Stat. Auth.: ORS 409.050, 410.070

Stats. Implemented: ORS 430.610, 430.630, 430.662, 430.670
Hist.: SPD 14-2011, f. & cert. ef. 7-1-11; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 31-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0027
Qualification for Employment Services

(1) To be eligible for employment services an individual must:

(a) Be an Oregon resident;

(b) Be determined eligible for developmental disability services by the CDDP of the county of origin as described in OAR 411-320-0080;

(c) Meet the level of care as defined in OAR 411-320-0020;

(d) Be eligible for the Comprehensive Services Waiver or Support Services Waiver;

(e) Be legally eligible to work in the United States;

(f) Have services under these rules authorized in an ISP by the CDDP or Brokerage providing case management services; and

(g) Have an employment related goal in the ISP as outlined under these rules and the case management rules in OAR chapter 411, division 415. An employment related goal means a goal related to obtaining, maintaining, or advancing in competitive integrated employment, or, at minimum, exploring competitive integrated employment.

(2) Employment services for individuals under the age of 18 years must have Department approval. The provider must retain documentation of the approval.

(3) As of October 1, 2014, an individual receiving medical benefits under OAR chapter 410, division 200 requesting Medicaid coverage for services in a nonstandard living arrangement (see OAR 461-001-0000) is subject to the requirements of the rules regarding transfer of assets (see OAR 461-140-0210 to 461-140-0300) in the same manner as if the individual was requesting these services under OSIPM.

(a) This includes, but is not limited to, the following assets:

(A) An annuity evaluated according to OAR 461-145-0022;

(B) A transfer of property when an individual retains a life estate evaluated according to OAR 461-145-0310;

(C) A loan evaluated according to OAR 461-145-0330; or

(D) An irrevocable trust evaluated according to OAR 461-145-0540.

(b) When an individual is considered ineligible due to a disqualifying transfer of assets, the individual must receive a notice meeting the requirements of OAR 461-175-0310 in the same manner as if the individual was requesting services under OSIPM.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670
Hist.: APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0030
Provider Requirements

(1) Available provider types. A provider of employment services must be:

(a) A provider certified and endorsed under OAR chapter 411, division 323;

(b) A provider certified under OAR 411-340-0170 (Standards for Provider Organizations) prior to January 1, 2016. Providers certified under OAR 411-340-0170 prior to January 1, 2016 must certify under OAR chapter 411, division 323 upon re-certification; or

(c) A qualified independent provider. Independent providers who are employed by the individual may only provide job coaching. Independent providers who are independent contractors may only provide job development and discovery.

(2) PROVIDER REQUIREMENTS:

(a) The provider must complete enrollment requirements outlined under OAR chapter 411, division 370. As part of enrollment, the provider must complete a Department designated assessment for each setting in which employment services are provided.

(b) Providers must meet requirements regarding Medicaid Performing Provider Numbers as described under OAR chapter 411, division 370.

(c) Providers must have a job description for its employment professionals or Service Agreement with clearly stated job responsibilities or service requirements. The job description or Service Agreement must be current, signed, and dated by the provider. Job descriptions for providers must also include duties specific to the area of specialization.

(d) A provider agency must have at least one employee in a supervisory position who has the Department approved credentialing. Providers independently contracted to provide an employment service must have the Department approved credentialing.

(3) EMPLOYMENT PROFESSIONAL REQUIREMENTS.

(a) Each employment professional must possess and demonstrate the following qualifications:

(A) Knowledge of developmental disabilities services.

(B) Knowledge of best practice methodologies regarding employment services.

(C) All core competencies for employment services must be demonstrated within one year of employment. Documentation that the employment professional has demonstrated these competencies must be maintained in the personnel file.

(D) Knowledge of the rules governing employment services.

(E) Ability to provide services designed to support successful employment outcomes consistent with individualized career goals, including goals identified in the ISP and Career Development Plan.

(F) Ability to support individuals to maintain and be successful in employment.

(G) Demonstrate by background, education, references, skills, and abilities that the employment professional is capable of safely and adequately performing the tasks to support the Service Agreement or ISP and Career Development Plan for an individual, including:

(i) Ability and sufficient education to follow oral and written instructions and keep any records required;

(ii) Responsibility, maturity, and reputable character exercising sound judgment;

(iii) Ability to communicate with the individual; and

(iv) Training of a nature and type sufficient to ensure that the employment professional has knowledge of emergency procedures specific to the individual receiving services.

(b) A job development provider must be qualified as a vendor of Vocational Rehabilitation job placement in order to provide the job development service.

(c) A discovery provider must be qualified as a vendor of Vocational Rehabilitation job placement in order to provide the discovery service.

(4) EMPLOYMENT PROFESSIONAL TRAINING:

(a) All employment professionals must complete an initial competency based employment training as follows:

(A) Employment professionals providing job coaching must complete at least one Department approved training for job coaching within 90 days of providing job coaching.

(B) Employment professionals providing job development must complete at least one Department approved training for job developers within 90 days of providing job development.

(C) Employment professionals providing discovery must complete at least one Department approved training for discovery before being authorized to provide discovery.

(D) Employment professionals providing small group services must complete at least one Department approved training within 90 days of providing small group.

(E) Employment professionals providing employment path must complete at least one Department approved training for employment path providers within 90 days of providing employment path services.

(b) All employment professionals must also complete annual training requirements.

(c) Documentation that the employment professionals have completed these training requirements must be maintained in the personnel file of the employment professional.

(5) DISQUALIFICATION. Employment professionals must self-report any potentially disqualifying condition as described in OAR 407-007-0280 (Potentially Disqualifying Conditions) and OAR 407-007-0290 (Other Potentially Disqualifying Conditions). The employment professionals must notify the Department or the designee of the Department within 24 hours.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 430.610, 430.662, 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 309-047-0010, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 5-2011(Temp), f. & cert. ef. 2-7-11 thru 8-1-11; 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; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 31-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0085
Reports and Recordkeeping

(1) PROGRESS NOTES.

(a) Providers must maintain regular progress notes regarding the employment service provided. The progress note must include, at minimum, the following information regarding the service rendered:

(A) Date and time the service was provided;

(B) Information regarding progress towards achieving the intended employment goal for which the employment service was utilized, including progress towards outcomes and milestones outlined in the Career Development Plan and the implementation strategies or plan;

(C) At least every six months, documentation of the number of hours the supported individual works, the wages and level of benefits, as well as any any opportunities presented to the individual for increased work hours; and

(D) Any discussion about work hours and related goals.

(b) Progress notes must be made available upon request.

(2) For each individual supported, providers being paid for job development services must report activity at least monthly to the services coordinator or personal agent for the individual.

(3) For each individual supported, providers being paid for discovery services must complete a Discovery Profile and submit the Discovery Profile to the services coordinator or personal agent for the individual.

(4) All documentation required by these rules, unless stated otherwise, must:

(a) Be prepared at the time, or immediately following the event being recorded;

(b) Be accurate and contain no willful falsifications;

(c) Be legible, dated, and signed by the person making the entry; and

(d) Be maintained for no less than five years.

Stat. Auth.: ORS 409.050, 430.662

Stats. Implemented: ORS 430.610, 430.662, 430.670

Hist.: APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 31-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0095

Service and Payment Limitations

(1) Employment service rates authorized in Department payment and reporting systems are paid to providers for delivering services, as described in these rules, and shall be based upon the Collective Bargaining Agreement and the Rate Schedule.

(2) Only one hourly employment service may be billed per individual per hour. Payments based on an outcome for job development and discovery are not in conflict with payments made based on direct service delivery.

(3) Employment services and payment for employment services are limited to:

(a) An average of 25 hours per week for any combination of job coaching, small group employment support, and employment path services; and

(b) 40 hours in any one week for job coaching if job coaching is the only service utilized.

(4) Exceptions to the service and payment limitations may be considered by the Department based upon applicable Department policy.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 430.670

Hist.: SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0110

Individuals' Rights

(1) A provider agency must have and implement written policies and procedures that protect the rights of individuals described in OAR 411-318-0010 (Individual Rights) and encourage and assist individuals to understand and exercise these rights.

(2) Upon entry and request and annually thereafter, the individual rights described in OAR 411-318-0010 (Individual Rights) must be provided to an individual and the legal or designated representative of the individual.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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 309-047-0050, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; 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 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 31-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0130

Complaints, Notification of Planned Action, and Hearings

(1) INDIVIDUAL COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015.

(b) A provider agency must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015.

(c) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(2) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disability service is denied, reduced, suspended, or terminated or voluntarily reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(3) HEARINGS.

(a) Hearings are addressed in accordance with ORS Chapter 183 and OAR 411-318-0025.

(b) An individual may request a hearing as provided in ORS Chapter 183 and OAR 411-318-0025 for a denial, reduction, suspension, or termination of a developmental disability service.

(c) Upon entry and request, and, at minimum, annually, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0060, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; 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 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0140

Entry, Exit, and Transfer Requirements for a Provider Agency

(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) ENTRY. A provider agency must participate in an entry ISP team meeting when requested by the individual. A provider agency may require an entry meeting as a condition of employment services.

(a) Prior to or upon an entry ISP team meeting, a provider agency must acquire or demonstrate efforts to acquire and then maintain the following information:

(A) A copy of the Career Development Plan and an ISP or Service Agreement;

(B) All information related to the employment goals and interests of the individual. This may include, but is not limited to, provider implementation strategies, documentation available through Vocational Rehabilitation or the local school, or a Discovery Profile;

(C) A copy of the Service Agreement or job description; and

(D) Any other documentation required by a provider, and that is consistent with requirements under OAR chapter 411, division 415 (regarding case management).

(b) Prior to or during an entry ISP team meeting, or prior to the commencement of employment services, a provider must develop a preliminary written plan or implementation strategies that includes measurable goals and milestones to support the individual to achieve career goals and outcomes outlined in the Career Development Plan. Within 60 days of an ISP team meeting, or the start of services, the provider must update, revise, or further refine the written plan or implementation strategies to reflect updates from the ISP team meeting and updates to the Career Development Plan. The plan or strategies may become part of the Service Agreement or job description.

(3) VOLUNTARY TRANSFERS AND EXITS.

(a) A provider agency must promptly notify a services coordinator or personal agent if an individual gives notice of the intent to exit services or abruptly exits services.

(b) A provider agency must notify a services coordinator or personal agent prior to the voluntary transfer or exit of an individual from services.

(c) Notification and authorization of the voluntary transfer or exit of the individual must be documented in the record for the individual.

(4) INVOLUNTARY REDUCTIONS, TRANSFERS, AND EXITS.

(a) A provider agency may only reduce, transfer, or exit an individual or group of individuals involuntarily for one or more of the following reasons:

(A) The behavior of the individual poses an imminent risk of danger to self or others;

(B) The individual experiences a medical emergency;

(C) The service needs of the individual exceed the ability of the provider agency; or

(D) The certification or endorsement for the provider agency described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) A notice of involuntary reduction, transfer, or exit is not required when an employment relationship between a community or general employer terminates. Notice requirements must be met if the job or work experience is in a provider owned, controlled, or operated setting or facility.

(c) NOTICE OF INVOLUNTARY INDIVIDUAL REDUCTION, TRANSFER, OR EXIT.

(A) A provider agency must not reduce services, transfer, or exit an individual involuntarily without 30 calendar days advance written notice to the individual, the legal or designated representative of the individual (as applicable), and the services coordinator or personal agent, 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 (B) of this section.

(i) The written notice must be provided on the Notice of Involuntary Reduction, Transfer, or Exit form approved by the Department and include:

(I) The reason for the reduction, transfer, or exit; and

(II) The right of the individual to a hearing as described in subsection (e) of this section.

(ii) A Notice of Involuntary Reduction, Transfer, or Exit is not required when an individual requests the reduction, transfer, or exit.

(B) A provider agency may give less than 30 calendar days advance 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, the legal or designated representative of the individual (as applicable), and the services coordinator or personal agent immediately upon determination of the need for a reduction, transfer, or exit.

(d) NOTICE OF INVOLUNTARY GROUP REDUCTION, TRANSFER, OR EXIT. If a provider agency reduces, transfers, or exits more than 10 individuals within any 30 calendar day period, the provider agency must provide 60 days advance written notice to the individuals and their legal or designated representatives (as applicable), the Department, and the services coordinators or personal agents.

(A) The written notice must be provided on the Notice of Involuntary Reduction, Transfer, or Exit form approved by the Department and include:

(i) The reason for the reduction, transfer, or exit; and

(ii) The right of the individual to a hearing as described in subsection (e) of this section.

(B) A Notice of Involuntary Reduction, Transfer, or Exit is not required when an individual requests the reduction, transfer, or exit.

(e) HEARING RIGHTS. An individual must be given the opportunity for a hearing under ORS Chapter 183 and OAR 411-318-0030 to dispute an involuntary reduction, transfer, or exit. If an individual requests a hearing, the individual must receive the same services until the hearing is resolved. When an individual has been given less than 30 calendar days advance written notice of a reduction, transfer, or exit as described in subsection (c) of this section and the individual has requested a hearing, the provider agency must reserve service availability for the individual until receipt of the Final Order.

(5) EXIT MEETING.

(a) The ISP team for an individual must meet before any decision is made to exit services. Findings of the exit meeting must be recorded in the file for the individual and include, at a minimum:

(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 exit of the individual from services (unless the individual is requesting the exit);

(F) Documentation of the decision regarding the exit of the individual, including verification of the voluntary decision to exit or a copy of the Notice of Involuntary Reduction, Transfer, or Exit; and

(G) Documentation of the proposed plan for services after the exit.

(b) Requirements for an exit meeting may be waived if an individual is immediately removed from services under the following conditions:

(A) The individual requests an immediate removal from services; or

(B) The individual is removed by legal authority acting pursuant to civil or criminal proceedings.

(6) TRANSFER MEETING. An ISP team must meet to discuss any proposed transfer of an individual from one site to another site before any decision to transfer is made. Findings of the transfer meeting must be recorded in the file for the individual 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 as applicable the legal or designated representative or family members of the individual, may not be honored;

(g) Documentation of the decision regarding the transfer of the individual, including verification of the voluntary decision to transfer or exit or a copy of the Notice of Involuntary Reduction, Transfer, or Exit; and

(h) The written plan for services after the transfer.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0160

Individual Support Plan and Career Development Plan

(1) A Career Development Plan must be completed as part of the ISP consistent with the case management requirements outlined under OAR chapter 411, division 415.

(2) Providers must implement the Service Agreement or ISP, Career Development Plan, provider implementation strategies, and any other related documents.

(3) A provider agency must:

(a) Assign a staff member to participate as a team member in the development of the ISP and Career Development Plan when invited by the individual;

(b) Follow any required process and format as described in this rule;

(c) Train staff to understand the Service Agreement or ISP, Career Development Plan, and supporting documents for each individual and to provide individual services; and

(d) Comply with Department rules and policies regarding the Service Agreement or ISP and Career Development Plan.

(4) When invited by the individual, a provider agency must participate in a face-to-face meeting annually with the ISP team.

(5) In preparation for the annual ISP meeting, the provider agency must do the following, regardless of whether the provider agency participates in the meeting:

(a) Gather person-centered information regarding preferences, interests, and desires of the individual supported;

(b) Review the current Service Agreement or ISP and Career Development Plan of the individual to determine the ongoing appropriateness and adequacy of the services and supports identified in the Service Agreement or ISP and Career Development Plan;

(c) Develop a preliminary written plan or provider implementation strategies including measurable goals to support the individual to achieve career goals and outcomes outlined in the Career Development Plan; and

(d) Share all materials drafted in preparation for the ISP meeting with the ISP team one week prior to the ISP meeting.

(6) Within 60 days after the annual ISP meeting, the provider must update, revise, or further refine the written plan or implementation strategies to reflect updates from the ISP team meeting and updates to the Career Development Plan. The plan or strategies may become part of the Service Agreement or job description.

(7) The provider agency must make reasonable efforts to obtain a copy of the Career Development Plan and a Service Agreement and supporting documents necessary for delivery of services.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0075, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 31-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16

411-345-0170

Behavior Support for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) The provider agency must have and implement a written policy for behavior support utilizing individualized positive support techniques and prohibiting abusive practices.

(2) The provider agency must inform the individual, and as applicable the legal or designated representative of the individual, of the behavior support policy and any applicable procedures at the time of entry to services and as changes to the behavior policy occur.

(3) Prior to the development of a Behavior Support Plan, the provider agency must conduct a functional behavioral assessment of the behavior, which must be based upon information provided by one or more people who know the individual. The functional behavioral assessment must include:

(a) A clear, measurable description of the behavior that includes (as applicable) frequency, duration, and intensity of the behavior;

(b) A clear description and justification of the need to alter the behavior;

(c) An assessment of the meaning of the behavior that includes the possibility that the behavior is one or more of the following:

(A) An effort to communicate;

(B) The result of a medical condition;

(C) The result of a psychiatric condition; or

(D) The result of environmental causes or other factors.

(d) A description of the context in which the behavior occurs; and

(e) A description of what currently maintains the behavior.

(4) A Behavior Support Plan must include:

(a) An individualized summary of the needs, preferences, and relationships of an individual;

(b) A summary of the functions of the behavior as derived from the functional behavioral assessment;

(c) Strategies that are related to the functions of the behavior and are expected to be effective in reducing problem behaviors;

(d) Prevention strategies, including environmental modifications and arrangements;

(e) Early warning signals or predictors that may indicate a potential behavioral episode and a clearly defined plan of response;

(f) A general crisis response plan that is consistent with OIS;

(g) A plan to address post crisis issues;

(h) A procedure for evaluating the effectiveness of the Behavior Support Plan that includes a method of collecting and reviewing data on frequency, duration, and intensity of the behavior;

(i) Specific instructions for staff who provide support to follow regarding the implementation of the Behavior Support Plan; and

(j) Positive behavior supports that includes the least intrusive intervention possible.

(5) The provider agency must maintain the following additional documentation for implementation of Behavior Support Plans:

(a) Written evidence that the individual, the legal or designated representative of the individual (as applicable), and the ISP team are aware of the development of the Behavior Support Plan and any objections or concerns;

(b) Written evidence of the ISP team decision for approval of the implementation of the Behavior Support Plan; and

(c) Written evidence of all informal and positive strategies used to develop an alternative behavior.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0080, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0180

Protective Physical Intervention for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) The provider agency must only employ protective physical intervention techniques that are included in the approved OIS curriculum or as approved by the OIS Steering Committee. Protective physical intervention techniques must only be applied:

(a) When the health and safety of the individual and others are at risk and the ISP team has authorized the procedures in a documented ISP team decision that is included in the ISP and uses procedures that are intended to lead to less restrictive intervention strategies;

(b) As an emergency measure if absolutely necessary to protect the individual or others from immediate injury; or

(c) As a health-related protection ordered by a physician if absolutely necessary during the conduct of a specific medical or surgical procedure, or for the protection of the individual during the time that a medical condition exists.

(2) Staff supporting an individual must be trained and certified in OIS when the individual has a history of behavior requiring protective physical intervention and the ISP team has determined there is probable cause for future application of protective physical intervention. Documentation verifying current OIS certification of staff must be maintained in the personnel file for the staff person and be available for review by the Department or the designee of the Department.

(3) The provider agency must obtain the approval of the OIS Steering Committee for any modification of standard OIS protective physical intervention techniques. The request for modification of protective physical intervention techniques must be submitted to the OIS Steering Committee and must be approved in writing by the OIS Steering Committee prior to the implementation of the modification. Documentation of the approval must be maintained in the record for the individual.

(4) Use of protective physical intervention techniques in emergency situations that are not part of an approved Behavior Support Plan must:

(a) Be reviewed by the executive director of the provider agency or the designee of the executive director within one hour of application;

(b) Be used only until the individual is no longer an immediate threat to self or others;

(c) Be documented as an incident report and submitted to the services coordinator, personal agent, or other Department designee (if applicable) and the legal representative of the individual (if applicable), no later than one business day after the incident has occurred; and

(d) Prompt an ISP team meeting if an emergency intervention is used more than three times in a six-month period.

(5) Any use of protective physical intervention must be documented in an incident report, excluding circumstances as described in section (8) of this rule. The incident report must include:

(a) The name of the individual to whom the protective physical intervention was applied;

(b) The date, type, and length of time the protective physical intervention was applied;

(c) A description of the incident precipitating the need for the use of the protective physical intervention;

(d) Documentation of any injury;

(e) The name and position of the staff member applying the protective physical intervention;

(f) The name and position of the staff witnessing the protective physical intervention;

(g) The name and position of the person providing the initial review of the use of the protective physical intervention; and

(h) Documentation of an administrative review by the executive director of the provider agency or the designee of the executive director who is knowledgeable in OIS as evident by a job description that reflects this responsibility, which includes the follow-up to be taken to prevent a recurrence of the incident.

(6) The provider agency must forward a copy of the incident report within five business days of the incident to the services coordinator or personal agent and the legal representative of the individual (if applicable).

(a) The services coordinator, personal agent, or the Department designee (if applicable) must receive a complete copy of the incident report.

(b) A copy of an incident report may not be provided to the legal representative or other provider agency of an individual when the report is part of an abuse or neglect investigation.

(c) A copy of an incident report provided to the legal representative or other service provider of an individual must have confidential information about other individuals removed or redacted as required by federal and state privacy laws.

(7) All protective physical interventions resulting in injuries must be documented in an incident report and forwarded to the services coordina-

tor, personal agent, or other Department designee (if applicable), within one business day of the incident.

(8) The provider agency may substitute a behavior data summary in lieu of individual incident reports when:

(a) There is no injury to the individual or others;

(b) There is a formal written functional behavioral assessment and a written Behavior Support Plan;

(c) The Behavior Support Plan defines and documents the parameters of the baseline level of behavior;

(d) The protective physical intervention techniques and the behaviors for which the protective physical intervention techniques are applied remain within the parameters outlined in the Behavior Support Plan for the individual and the OIS curriculum;

(e) The behavior data collection system for recording observation, intervention, and other support information critical to the analysis of the efficacy of the Behavior Support Plan is also designed to record items as required in section (5) of this rule; and

(f) There is written documentation of an ISP team decision that a behavior data summary had been authorized for substitution in lieu of incident reports.

(9) A copy of the behavior data summary must be forwarded every 30 calendar days to the services coordinator, personal agent, or other Department designee (if applicable) and the legal representative of an individual (if applicable).

Stat. Auth.: ORS 409.050 & 430.662
Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0085, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0190
Medical Services for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) All medical records for the individuals must be kept confidential as described in OAR 411-323-0060.

(2) The provider agency must have and implement written policies and procedures that describe the medical management system, including medication administration, early detection and prevention of infectious disease, self-administration of medication, drug disposal, emergency medical procedures including the handling of bodily fluids, and confidentiality of medical records.

(3) Individuals must receive care that promotes their health and well-being as follows:

(a) The provider agency must observe the health and physical condition of an individual and take action in a timely manner in response to identified changes in condition that may lead to deterioration or harm;

(b) The provider agency must assist an individual with the use and maintenance of prosthetic devices as necessary for the activities of the service;

(c) The provider agency, with the knowledge of the individual, must share information regarding medical conditions with the residential contact (if applicable) and the services coordinator or personal agent of the individual; and

(d) The provider agency must provide rest and lunch periods at least as required by applicable law unless the needs of the individual dictate additional time.

(4) The provider agency must maintain records on each individual to aid physicians, health care providers, and the provider agency in understanding the medical history and current treatment program for the individual. These records must be kept current and organized in a manner that permits a staff and health care provider to easily follow the course of treatment for the individual. Such documentation must include:

(a) A medical history obtained prior to entry to services including where available:

(A) A copy of a record of immunizations; and

(B) A list of known communicable diseases and allergies.

(b) A record of the current medical condition of the individual, including:

(A) A copy of all current orders for medication administered and maintained at the site of the provider agency;

(B) A list of all current medications; and

(C) A record of visits to health care providers if facilitated or provided by the provider agency.

(5) The administration of medication at the service site must be avoided whenever possible. When medications, treatments, equipment, or special diets must be administered or monitored for self-administration, the provider agency must:

(a) Obtain a copy of a written order signed by a physician, designee of a physician, or health care provider prescribing the medication, treatment, special diet, equipment, or other medical service; and

(b) Follow written orders.

(6) PRN orders are not accepted for psychotropic medication.

(7) All medications administered or monitored in the case of self-administration must be:

(a) Kept in their original containers;

(b) Labeled by the dispensing pharmacy, product manufacturer, or physician or health care provider, as specified per the written order of a physician or health care provider;

(c) Kept in a secured locked container and stored as indicated by the product manufacturer; and

(d) Recorded on an individualized Medication Administration Record (MAR), including treatments and PRN orders.

(8) The MAR must include:

(a) The name of the individual;

(b) The brand or generic name of the medication, including the prescribed dosage and frequency of administration as contained on the order of the physician or health care provider and medication;

(c) For topical medications and basic first aid treatments utilized without the order of a physician or health care provider, a transcription of the printed instructions from the package or the description of the basic first aid treatment provided;

(d) Times and dates of administration or self-administration of the medication;

(e) The signature of the staff administering the medication or monitoring the self-administration of the medication;

(f) Method of administration;

(g) Documentation of any known allergies or adverse reactions to a medication;

(h) Documentation and an explanation of why a PRN medication was administered and the results of such administration; and

(i) An explanation of any medication administration irregularity with documentation of administrative review by the executive director of the provider agency or the designee of the executive director.

(9) Safeguards to prevent adverse medication reactions must be utilized to include:

(a) Maintaining information about the effects and side-effects of each prescribed medication;

(b) Communicating any concerns regarding any medication usage, effectiveness, or effects to the residential contact (if applicable) and the services coordinator or personal agent; and

(c) Prohibiting the use of the medications of one individual by another individual.

(10) The service site or provider agency may not keep unused, discontinued, outdated, or recalled medication, or medication containers with worn, illegible, or missing labels. All unused, discontinued, outdated, or recalled medication or medication containers with worn, illegible, or missing labels must be promptly disposed of in a manner consistent with federal statutes and designed to prevent illegal diversion of the substances into the possession of people other than for whom the medication was prescribed. The provider agency must maintain a written record of all disposed medications that includes:

(a) Date of disposal;

(b) A description of the medication, including amount;

(c) The name of the individual for whom the medication was prescribed;

(d) The reason for disposal;

(e) The method of disposal;

(f) Signature of staff disposing; and

(g) For controlled medications, the signature of a witness to the disposal.

(11) For any individual who is self-administering medication while receiving services from a provider agency, the provider agency must:

(a) Have documentation that a training program was initiated with approval of the ISP team for the individual or that training for the individual is unnecessary;

(b) If necessary, have a training program that is consistent with the self-administration training program in place at the residence of the individual;

(c) If necessary, have a training program that provides for retraining when there is a change in dosage, medication, or time of delivery;

(d) Have specific supports identified and documented for the individual when training has been deemed unnecessary; and

(e) Provide for an annual review, at a minimum, as part of the ISP process, upon completion of the training program or when training for the individual has been deemed necessary by the ISP team.

(12) The provider agency must ensure that individuals able to self-administer medications keep the medications secured, unavailable to any other person, and stored as recommended by the product manufacturer.

(13) The provider agency must immediately contact the services coordinator or personal agent when the medical, behavioral, or physical needs of an individual change to a point that the needs of the individual may not be met by the provider agency. The ISP team may determine alternative service providers or may arrange other services if necessary.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0090, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; 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 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0200

Individual Summary Sheets and Emergency Information for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) The provider agency must maintain a current one to two page summary sheet record at the primary place of business of the provider agency for each individual receiving services. The record must include:

(a) The name of the individual and his or her current address, telephone number, date of entry into services, date of birth, gender, preferred hospital, medical prime and private insurance number (if applicable), and guardianship status; and

(b) The name, address, and telephone number of:

(A) The legal or designated representative, family, and other significant person of the individual (as applicable);

(B) The primary care provider and clinic preferred by the individual;

(C) The dentist preferred by the individual;

(D) The services coordinator or personal agent of the individual; and

(E) Other agencies and representatives providing services and supports to the individual.

(2) A provider agency must maintain emergency information for each individual receiving supports and services from the provider agency in addition to an individual summary sheet identified in section (1) of this rule. The emergency information must be kept current and must include:

(a) The name of the individual;

(b) The name, address, and telephone number of the provider agency;

(c) The address and telephone number of the residence where the individual lives;

(d) The physical description of the individual, which may include a picture and the date the picture was taken, and identification of:

(A) The race, gender, height, weight range, hair, and eye color of the individual; and

(B) Any other identifying characteristics that may assist in identifying the individual may the need arise, such as marks or scars, tattoos, or body piercing.

(e) Information on the abilities and characteristics of the individual, including:

(A) How the individual communicates;

(B) The language the individual uses or understands;

(C) The ability of the individual to know and take care of bodily functions; and

(D) Any additional information that may assist a person not familiar with the individual to understand what the individual may do for him or herself.

(f) The health support needs of the individual, including:

(A) Diagnosis;

(B) Allergies or adverse drug reactions;

(C) Health issues that a person needs to know when taking care of the individual;

(D) Special dietary or nutritional needs, such as requirements around the textures or consistency of foods and fluids;

(E) Food or fluid limitations due to allergies, diagnosis, or medications the individual is taking that may be an aspiration risk or other risk for the individual;

(F) Additional special requirements the individual has related to eating or drinking, such as special positional needs or a specific way foods or fluids are given to the individual;

(G) Physical limitations that may affect the ability of the individual to communicate, respond to instructions, or follow directions; and

(H) Specialized equipment needed for mobility, positioning, or other health-related needs.

(g) The emotional and behavioral support needs of the individual, including:

(A) Mental health or behavioral diagnosis and the behaviors displayed by the individual; and

(B) Approaches to use when dealing with the individual to minimize emotional and physical outbursts.

(h) Any court ordered or legal representative authorized contacts or limitations;

(i) The supervision requirements of the individual and why; and

(j) Any additional pertinent information the provider agency has that may assist in the care and support of the individual in the event of a natural or man-made disaster.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0095, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0230

Incident Reports and Emergency Notifications for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) A written incident report describing any injury, accident, act of physical aggression, or unusual incident involving an individual must be placed in the record for the individual. The incident report must include:

(a) Conditions prior to, or leading to, the incident;

(b) A description of the incident;

(c) Staff response at the time; and

(d) Follow-up to be taken to prevent a recurrence of the injury, accident, physical aggression, or unusual incident.

(2) Copies of incident reports for all unusual incidents (as defined by OAR 411-317-0000) must be sent to the services coordinator or personal agent within five business days of the unusual incident.

(3) The provider agency must immediately notify the CDDP or Brokerage of an incident or allegation of abuse falling within the scope of OAR 407-045-0260.

(4) In the case of an unusual incident requiring emergency response, the provider agency must immediately notify:

(a) The legal representative, parent, next of kin, designated representative, and other significant person of the individual (as applicable);

(b) The CDDP or Brokerage;

(c) The residential contact of the individual; and

(d) Any other agency responsible for the individual.

(5) In the case of an individual who is missing or absent without supervision beyond the time frames established by the ISP team, the provider agency must immediately notify:

(a) The designated representative of the individual (if applicable);

(b) The legal representative of the individual or nearest responsible relative (as applicable);

(c) The residential contact of the individual;

(d) The local police department; and

(e) The CDDP or Brokerage.

Stat. Auth.: ORS 409.050 & 430.662

Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0110, 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 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0240

Emergency Plan and Safety Review for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) A provider agency must develop, keep current, and implement a written emergency plan for the protection of all individuals in the event of an emergency or disaster. The emergency plan must:

(a) Be practiced at least annually;

(b) Consider the needs of the individuals being supported and address all natural and human-caused events identified as a potential significant risk to the individuals, such as a pandemic or an earthquake;

(c) Coordinate with each residential provider or residential contact to address the possibility of emergency or disaster resulting in the following:

(A) Extended utility outage;

(B) No running water;

(C) Inability to provide food or supplies; and

(D) Staff unable to report as scheduled.

(d) Include provisions for evacuation and relocation that identifies:

(A) The duties of staff during evacuation, transport, and housing of individuals;

(B) The requirement for staff to notify the Department and the local CDDP and Brokerage offices of the plan to evacuate or the evacuation of the facility, as soon as the emergency or disaster reasonably allows;

(C) The method and source of transportation;

(D) Planned relocation sites that are reasonably anticipated to meet the needs of the individuals;

(E) A method that provides a person unknown to the individual the ability to identify the individual by name and to identify the name of the provider agency for the individual; and

(F) A method for tracking and reporting to the Department, local CDDP and Brokerage offices, or designee, the physical location of each individual until a different entity resumes responsibility for the individual.

(e) Address the needs of the individual, including medical needs; and

(f) Be submitted to the Department as a summary, per Department format, at least annually and upon revision and change of ownership.

(2) A provider agency must post the following emergency telephone numbers in close proximity to all phones used by staff:

(a) The telephone numbers of the local fire, police department, and ambulance service, if not served by a 911 emergency service; and

(b) The telephone number of the executive director of the provider agency and additional people to be contacted in the case of an emergency.

(3) If an individual regularly accesses the community independently, the provider agency must provide the individual information about appropriate steps to take in an emergency, such as emergency contact telephone numbers, contacting police or fire personnel, or other strategies to obtain assistance.

(4) A documented safety review must be conducted quarterly to ensure the service site is free of hazards. The provider agency must keep the quarterly safety review reports for five years and must make them available upon request by the CDDP, Brokerage, or the Department.

Stat. Auth.: ORS 409.050 & 430.662
Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0115, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0250
Evacuation for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) The provider agency must train all individuals immediately upon entry to each service site to leave the site in response to an alarm or other emergency signal.

(2) The provider agency must document the level of assistance needed by each individual to safely evacuate and such documentation must be maintained in the entry records for the individual.

(3) The provider agency must provide, or assure provision of, necessary adaptations or accommodations to ensure evacuation safety for individuals with sensory and physically impairments.

(4) A site-based provider agency must:

(a) Conduct unannounced evacuation drills one per quarter each year when individuals are present, unless required more often by the Oregon Occupational Safety and Health Division.

(A) Drills must occur at different times of the day.

(B) Routes to leave the site for the drill must vary based on the location of a simulated emergency.

(C) Any individual failing to evacuate the service site unassisted within three minutes, or an amount of time set by the local fire authority for the site, must be provided specialized training and support in evacuation procedures.

(b) Make written documentation at the time of each drill and keep the documentation for at least two years following the drill. Documentation must include:

(A) The date and time of the drill;

(B) The location of the simulated emergency and route of evacuation;

(C) The last names of all individuals and staff present in the service area at the time of the drill;

(D) The type of evacuation assistance provided by staff to individuals that need more than three minutes to evacuate as specified in the safety plan for the individuals;

(E) The amount of time required by each individual to evacuate if the individual needs more than three minutes to evacuate;

(F) The amount of time for all individuals to evacuate exclusive of individuals with specialized support as described in section (3)(c) of this rule; and

(G) The signature of the staff conducting the drill.

(c) Develop a written safety plan for individuals who are unable to evacuate the site within the required evacuation time or who, with concurrence of the ISP team, request not to participate in evacuation drills. The safety plan must include:

(A) Documentation of the risk to the medical, physical condition, and behavioral status of the individual;

(B) Identification of how the individual must evacuate the site, including level of support needed;

(C) The routes to be used to evacuate the individual to a point of safety;

(D) Identification of assistive devices required for evacuation;

(E) The frequency the plan must be practiced and reviewed by the individual and staff;

(F) The alternative practices;

(G) Approval of the plan by the legal representative of the individual, services coordinator or personal agent, and the executive director of the provider agency; and

(H) A plan to encourage future participation in evacuation drills.

Stat. Auth.: ORS 409.050 & 430.662
Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0120, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0260
Physical Environment for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) A provider agency must ensure that the service site has no known health or safety hazards in its immediate environment and that individuals are trained to avoid recognizable hazards.

(2) The provider agency must:

(a) Assure that at least once every five years a health and safety inspection is conducted of owned, leased, or rented buildings and property.

(A) The inspection must cover all areas and buildings where services are delivered to individuals, administrative offices, and storage areas.

(B) The inspection may be performed by:

(i) Oregon Occupational Safety and Health Division;

(ii) The workers compensation insurance carrier of the provider agency;

(iii) An appropriate expert, such as a licensed safety engineer or consultant approved by the Department; or

(iv) The Oregon Public Health Division, when necessary.

(C) The inspection must cover:

(i) Hazardous material handling and storage;

(ii) Machinery and equipment used by the provider agency;

(iii) Safety equipment;

(iv) Physical environment; and

(v) Food handling, when necessary.

(D) The documented results of the inspection, including recommended modifications or changes, and documentation of any resulting action taken must be kept by the provider agency for five years.

(b) Ensure buildings and property at each owned, leased, or rented service site has annual fire and life safety inspections performed by the local fire authority or a Deputy State Fire Marshal. The documented results of the inspection, including documentation of recommended modifications

or changes, and documentation of any resulting action taken must be kept by the provider agency for five years.

Stat. Auth.: ORS 409.050 & 430.662
Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0125, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 5-2011(Temp), f. & cert. ef. 2-7-11 thru 8-1-11; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

411-345-0270
Vehicles and Drivers for a Provider Agency

For a provider agency certified by the Department to deliver services under these rules and endorsed under the rules in OAR chapter 411, division 323:

(1) A provider agency that owns or operates vehicles that transports individuals must:

(a) Maintain the vehicles in safe operating condition;

(b) Comply with the laws of the Driver and Motor Vehicle Services Division;

(c) Maintain insurance coverage; and

(d) Carry a first-aid kit in the vehicles.

(2) A driver operating vehicles to transport individuals must meet all applicable requirements of the Driver and Motor Vehicle Services Division.

Stat. Auth.: ORS 409.050 & 430.662
Stats. Implemented: ORS 430.610, 430.662, 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; Renumbered from 309-047-0130, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 61-2013, f. 12-27-13, cert. ef. 12-28-13; APD 27-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 45-2014, f. 12-26-14, cert. ef. 12-28-14; APD 22-2016, f. & cert. ef. 6-29-16

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Rule Caption: ODDS: Supported Living Programs for Adults with Intellectual or Developmental Disabilities
Adm. Order No.: APD 23-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 4-1-2016
Rules Adopted: 411-328-0625
Rules Amended: 411-328-0550, 411-328-0560, 411-328-0640, 411-328-0650, 411-328-0700, 411-328-0720, 411-328-0750, 411-328-0760, 411-328-0770, 411-328-0780, 411-328-0790
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the rules in OAR chapter 411, division 328 for supported living programs for adults with intellectual or developmental disabilities.

These rules are being updated to:

- Make permanent temporary changes that became effective on January 1, 2016;

- Provide consistency across services by removing terms included in the general definitions rule, OAR 411-317-0000;

- Provide clarity on the roles of supported living providers in entry, exit, and service planning;

- Incorporate the adoption of the rules for home and community-based (HCB) services and settings and person-centered service planning in OAR chapter 411, division 004;

- Incorporate the individual rights in OAR 411-318-0010 for individuals receiving HCB services; and

- Reflect current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

The rules in OAR chapter 411, division 004 implement the regulations and expectations of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) by providing a foundation of standards to support the network of Medicaid-funded and private pay residential and non-residential HCB services and settings and person-centered service planning.

When an individual resides in a dwelling that is owned, rented, or leased by an agency endorsed to provide supported living services and the same agency is authorized to provide services to the individual, the dwelling is considered a provider owned, controlled, or operated residential setting and must have all the following qualities:

- The setting is integrated in and supports the same degree of access to the greater community as people not receiving HCB services, including opportunities for individuals enrolled in or utilizing HCB services to seek employment and work in competitive integrated employment settings, engage in greater community life, control personal resources, and receive services in the greater community;

- The setting is selected by an individual, or as applicable the legal or designated representative of the individual, from among available setting options, including non-disability specific settings and an option for a private unit in a residential setting;

- The setting ensures individual rights of privacy, dignity, respect, and freedom from coercion and restraint;

- The setting optimizes, but does not regiment, individual initiative, autonomy, self-direction, and independence in making life choices including, but not limited to, daily activities, physical environment, and with whom to interact;

- The setting facilitates individual choice regarding services and supports, and who provides the services and supports;

- The setting is physically accessible to an individual;

- The unit is a specific physical place that may be owned, rented, or occupied by an individual under a legally enforceable Residency Agreement;

- Each individual has privacy in his or her own unit;

- Units have entrance doors lockable by the individual, with the individual and only appropriate staff having a key to access the unit;

- Individuals sharing units have a choice of roommates;

- Individuals have the freedom to decorate and furnish his or her own unit as agreed to within the Residency Agreement;

- Individuals may have visitors of their choosing at any time;

- Each individual has the freedom and support to control his or her own schedule and activities; and

- Each individual has the freedom and support to have access to food at any time.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-328-0550
Statement of Purpose

(1) The rules in OAR chapter 411, division 328 prescribe standards for providers that support individuals with intellectual or developmental disabilities in a supported living setting and the procedures for the certification and endorsement of supported living settings under the rules in OAR chapter 411, division 323.

(2) These rules incorporate the provisions for home and community-based services and settings and person-centered service planning set forth in OAR chapter 411, division 004. These rules and the rules in OAR chapter 411, division 004 ensure individuals with intellectual or developmental disabilities receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving home and community-based services.

(3) Supported living provides the opportunity for an individual to live in the residence of his or her choice within the community with recognition that the needs and preferences of the individual may change over time. The levels of support for the individual are based upon individual needs and preferences as identified in a functional needs assessment and defined in an Individual Support Plan. Such services may include up to 24 hours per day of paid supports that are provided in a manner that protects the dignity of the individual.

(4) These rules ensure that providers meet basic management, programmatic, health and safety, and human rights regulations for individuals receiving services funded by the Department in supported living settings. The provider is responsible for developing and implementing policies and procedures that ensure that the requirements of these rules are met and ensuring services comply with all applicable local, state, and federal laws and regulations.

Stat. Auth.: ORS 409.050 &430.662
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 309-041-0550 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 33-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0560
Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 328:

(1) "Board of Directors" means the group of people formed by the provider agency to set policy and give directions to a provider delivering supports to individuals in a community-based service setting. A board of directors may include local advisory boards used by multi-state organizations.

(2) "CDDP" means "Community Developmental Disabilities Program".

(3) "Certificate" means the document issued by the Department to a provider that certifies the provider is eligible under the rules in OAR chapter 411, division 323 to receive state funds for the provision of services in an endorsed supported living setting.

(4) "Endorsement" means the authorization to provide services in a supported living setting that is issued by the Department to a certified provider that has met the qualification criteria outlined in these rules and the rules in OAR chapter 411, division 323.

(5) "Executive Director" means the person designated by a board of directors or corporate owner that is responsible for the administration of services in a supported living setting.

(6) "Functional Needs Assessment":

(a) Means the comprehensive assessment or reassessment that:

(A) Documents physical, mental, and social functioning;

(B) Identifies risk factors and support needs; and

(C) Determines the service level.

(b) The functional needs assessment for an adult is known as the Adult Needs Assessment (ANA). The Department incorporates Version C of the ANA into these rules by this reference. The ANA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm. A printed copy of a blank ANA may be obtained by calling (503) 945-6398 or writing to the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

(7) "Individual" means an adult applying for, or determined eligible for, Department-funded developmental disabilities services.

(8) "Individual Profile" means the written profile that describes an individual entering into a supported living setting. The profile may consist of materials or assessments generated by a provider or other related agencies, consultants, family members, or the legal or designated representative of the individual (as applicable).

(9) "ISP" means "Individual Support Plan".

(10) "OIS" means "Oregon Intervention System".

(11) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(12) "Provider" means a public or private community agency or organization that provides recognized developmental disabilities 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.

(13) "Supported Living" means the endorsed program that provides the opportunity for individuals to live in the 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.

(14) "These Rules" mean the rules in OAR chapter 411, division 328.

(15) "Unit" means the personal space and bedroom of an individual receiving home and community-based services in a provider owned, controlled, or operated residential setting, as agreed to in the Residency Agreement.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 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; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 33-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0625
Provider Owned, Controlled, or Operated Residential Settings

(1) When an individual resides in a provider owned, controlled, or operated residential setting, the provider must assure that the setting complies with the qualities in OAR 411-004-0020 no later than September 1, 2018.

(2) Settings are considered provider owned, controlled, or operated when the provider authorized to deliver services to the individual:

(a) Owns, rents, leases, or co-leases the setting where the services are delivered; or

(b) Has a direct or indirect financial relationship with the owner of the property.

(3) RESIDENCY AGREEMENTS.

(a) The provider must enter into a written Residency Agreement with each individual specifying, at a minimum, the following:

(A) The rights and responsibilities of the individual and the provider; and

(B) The eviction process, notice requirements, and appeal rights available to each individual.

(b) The Residency Agreement may not violate the rights of an individual as stated in OAR 411-318-0010.

(c) The Residency Agreement may not be in conflict with any of these rules, the certification and endorsement rules in OAR chapter 411, division 323, or the home and community-based services and settings rules in OAR chapter 411, division 004.

(d) Prior to implementing changes to the Residency Agreement, the Residency Agreement may be subject to review and approval by the Department or the designee of the Department.

(e) The provider must review the Residency Agreement with and provide a copy to each individual and the legal representative of the individual, as applicable, at the time of entry and annually or as changes occur. The reviews must be documented by having the individual, or the legal representative of the individual, sign and date a copy of the Residency Agreement. A copy of the signed and dated Residency Agreement must be maintained in the record for the individual.

(4) INDIVIDUALLY-BASED LIMITATIONS.

(a) For an initial or annual ISP authorized to begin on or after March 1, 2017, the provider must identify any individually-based limitations to the following freedoms:

(A) Support and freedom to access the individual's personal food at any time;

(B) Visitors of the individual's choosing at any time;

(C) A lock on the individual's unit, lockable by the individual;

(D) Choice of a roommate, if sharing a bedroom;

(E) Freedom to furnish and decorate the individual's bedroom as the individual chooses in accordance with the Residency Agreement; and

(F) Freedom and support to control the individual's schedule and activities.

(b) All individually-based limitations must be included in the ISP no later than February 28, 2018.

(c) An individually-based limitation to any freedom in subsection (a) of this section must be supported by a specific assessed need due to threats to the health and safety of the individual or others. The provider must incorporate and document all applicable elements identified in OAR 411-004-0040, including:

(A) The specific and individualized assessed need justifying the individually-based limitation;

(B) The positive interventions and supports used prior to any individually-based limitation;

(C) Less intrusive methods that have been tried but did not work;

(D) A clear description of the condition that is directly proportionate to the specific assessed need;

(E) Regular reassessment and review to measure the ongoing effectiveness of the individually-based limitation;

(F) Established time limits for periodic review of the individually-based limitation to determine if the individually-based limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually;

(G) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative; and

(H) An assurance that the interventions and support do not cause harm to the individual.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 430.670
Hist.: APD 33-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0640
Dietary

(1) The provider is responsible for providing the support and guidance identified in the ISP to ensure individuals are provided access to a nutritionally adequate diet.

(2) Written dietary supports must be developed as required by an ISP team and integrated into a Transition Plan or ISP. The plan must be based on a review and identification of the dietary service needs and preferences of an individual and updated annually or as significant changes occur.

(3) The provider must have and implement policies and procedures related to maintaining adequate food supplies and meal planning, preparation, service, and storage.

(4) The provider must support the freedom of the individual to have access to the individual's personal food at any time.

Stat. Auth.:ORS 409.050 &430.662
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 309-041-0640 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0650
Physical Environment

(1) All floors, walls, ceilings, windows, furniture, and fixtures must be maintained. The interior and exterior must be safely maintained and accessible according to the needs of the individuals.

(2) The water supply and sewage disposal must meet the requirements of the current rules of the Oregon Health Authority governing domestic water supply.

(3) Each residence must have:

(a) A kitchen area for the preparation of hot meals; and

(b) A bathroom containing a properly operating toilet, handwashing sink, and a bathtub or shower.

(4) Each residence must be adequately heated and ventilated.

Stat. Auth.:ORS 409.050 &430.662
Stats. Implemented: ORS 430.610, 430.630 & 430.670
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; Renumbered from 309-041-0650 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 33-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0700
Incident Reports and Emergency Notifications

(1) An incident report, as defined in OAR 411-328-0560, must be placed in the record for an individual upon injury, accident, act of physical aggression, or unusual incident. The incident report must include:

(a) Conditions prior to, or leading to, the incident;

(b) A description of the incident;

(c) Staff response at the time; and

(d) Follow-up to be taken to prevent a recurrence of the incident.

(2) A copy of all incident reports must be sent or made electronically available to the case manager within five business days of the incident.

(3) Upon request of the legal representative, a copy of the incident report must be sent or made electronically available to the legal representative within five business days of the incident. If a copy of the incident report is sent or made electronically available to the legal representative of an individual, any confidential information about other individuals must be removed or redacted as required by federal and state privacy laws. A copy of an incident report may not be provided to the legal representative of an individual when the report is part of an abuse or neglect investigation.

(4) The provider must immediately notify the case management entity if an incident or allegation falls within the scope of abuse as defined in OAR 407-045-0260.

(5) In the case of a serious illness, injury, or death of an individual, the provider must immediately notify:

(a) The legal or designated representative, parent, next of kin, and other significant person of the individual (as applicable);

(b) The case management entity; and

(c) Any other agency responsible for the individual.

(6) In the case of an individual who is missing beyond the timeframes established by the ISP team, the provider must immediately notify:

(a) The designated representative of the individual;

(b) The legal representative of the individual, if any, or nearest responsible relative;

(c) The local police department; and

(d) The case management entity.

Stat. Auth.: ORS 409.050 &430.662
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 309-041-0700 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0720
Individual Rights, Complaints, Notification of Planned Action, and Hearings

(1) INDIVIDUAL RIGHTS.

(a) A provider must protect the rights of individuals described in OAR 411-318-0010 and encourage and assist individuals to understand and exercise these rights.

(b) Upon entry and request and annually thereafter, the individual rights described in OAR 411-318-0010 must be provided to an individual and the legal or designated representative of the individual.

(2) COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015.

(b) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(3) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disability service is denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(4) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(b) An individual or the legal or designated representative of the individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025 for a denial, reduction, suspension, or termination of a developmental disability service or OAR 411-318-0030 for an involuntary reduction, transfer, or exit.

(c) Upon entry and request and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050 &430.662
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 309-041-0720 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 33-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0750
Personalized Plans

(1) The following information must be collected and summarized by the provider prior to any ISP meeting:

(a) One page profile reflecting, at a minimum, information gathered by the site where the individual receives services;

(b) Person-centered information reflecting, at a minimum, information gathered by the site where the individual receives services; and

(c) Information about known, identified serious risks.

(2) The following information must be developed by the provider and shared with the case manager and the individual, or if applicable the legal or designated representative of the individual, as directed by the ISP or Service Agreement.

(a) Implementation strategies, such as action plans, for desired outcomes or goals.

(b) Necessary protocols or plans that address health, behavioral, safety, and financial supports.

(c) A summary of the provider risk management strategies in place, including title of document, date, and where it is kept.

(d) A Nursing Service Plan, if applicable.

(e) Other documents required by the ISP team.

(3) The provider must maintain a copy of the ISP or Service Agreement provided the case management entity and signed by the provider.

(4) The provider must participate in ISP team meetings as requested by the individual or the legal or designated representative of the individual (if applicable).

(5) The provider must maintain documentation of implementation of each support and services specified in sections (2)(a) to (2)(e) of this rule in the ISP or Service Agreement for the individual. This documentation must be kept current and be available for review by the individual, the legal representative of the individual, the case management entity, and Department representatives.

(6) INDIVIDUAL PROFILE.

(a) The provider must develop a written profile within 90 days of entry. The profile is used to train new staff. The profile must include information related to the history or personal highlights, lifestyle and activity choices and preferences, social network and significant relationships, and other information that helps describe an individual.

(b) The profile must be composed of written information generated by the provider. The profile may include:

(A) Reports of assessments or consultations;

(B) Historical or current materials developed by the case management entity or nursing facility;

(C) Material and pictures from the family and friends of the individual;

(D) Newspaper articles; and

(E) Other relevant information.

(c) The profile must be maintained at the service site and updated as significant changes occur.

Stat. Auth.: ORS 409.050 &430.662
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 309-041-0750 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 33-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0760
Behavior Support

(1) The provider must have and implement a written policy for behavior support that utilizes individualized positive behavioral theory and practice and prohibits abusive practices.

(2) The provider must inform an individual and, as applicable, the legal or designated representative of the individual, of the behavior support policy and procedures at the time of entry and as changes occur.

(3) A decision to develop a plan to alter a behavior must be made by the ISP team.

(4) The behavior consultant or a trained staff member must conduct a functional behavioral assessment of the behavior that is based upon information provided by one or more people who know the individual. The functional behavioral assessment must include:

(a) A clear, measurable description of the behavior, including frequency, duration, and intensity of the behavior (as applicable);

(b) A clear description and justification of the need to alter the behavior;

(c) An assessment of the meaning of the behavior, including the possibility that the behavior is one or more of the following:

(A) An effort to communicate;

(B) The result of a medical condition;

(C) The result of a psychiatric condition; or

(D) The result of environmental causes or other factors.

(d) A description of the context in which the behavior occurs; and

(e) A description of what currently maintains the behavior.

(5) The Behavior Support Plan must include:

(a) An individualized summary of the needs, preferences, and relationships of the individual;

(b) A summary of the function of the behavior as derived from the functional behavioral assessment;

(c) Strategies that are related to the function of the behavior and are expected to be effective in reducing problem behaviors;

(d) Prevention strategies, including environmental modifications and arrangements;

(e) Early warning signals or predictors that may indicate a potential behavioral episode and a clearly defined plan of response;

(f) A general crisis response plan that is consistent with OIS;

(g) A plan to address post crisis issues;

(h) A procedure for evaluating the effectiveness of the Behavior Support Plan, including a method of collecting and reviewing data on frequency, duration, and intensity of the behavior;

(i) Specific instructions for staff who provide support to follow regarding the implementation of the Behavior Support Plan; and

(j) Positive behavior supports that includes the least intrusive intervention possible.

(6) Providers must maintain the following additional documentation for implementation of a Behavior Support Plan:

(a) Written evidence that the individual, the legal or designated representative of the individual (if applicable), and the ISP team are aware of the development of the Behavior Support Plan and any objections or concerns have been documented;

(b) Written evidence of the ISP team decision for approval of the implementation of the Behavior Support Plan; and

(c) Written evidence of all informal and positive strategies used to develop an alternative behavior.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 430.610, 430.662, 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 309-041-0760 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0770
Protective Physical Intervention

(1) The provider must only employ protective physical intervention techniques that are included in the current approved OIS curriculum or as approved by the OIS Steering Committee. Protective physical intervention techniques must only be applied:

(a) When the health and safety of the individual or others is at risk, the ISP team has authorized the procedures as documented by the decision of the ISP team, the procedures are documented in the ISP or Service Agreement, and the procedures are intended to lead to less restrictive intervention strategies;

(b) As an emergency measure if absolutely necessary to protect the individual or others from immediate injury; or

(c) As a health-related protection ordered by a licensed health care provider if absolutely necessary during the conduct of a specific medical or surgical procedure or for the protection of the individual during the time that a medical condition exists.

(2) Staff supporting an individual must be trained by an instructor certified in OIS when the individual has a history of behavior requiring protective physical intervention and the ISP team has determined there is probable cause for future application of protective physical intervention. Documentation verifying OIS training must be maintained in the personnel file for the staff person.

(3) The provider must obtain the approval of the OIS Steering Committee for any modification of standard OIS protective physical intervention techniques. The request for modification of a protective physical intervention technique must be submitted to the OIS Steering Committee and must be approved in writing by the OIS Steering Committee prior to the implementation of the modification. Documentation of the approval must be maintained in the record for the individual.

(4) Use of protective physical intervention techniques that are not part of an approved Behavior Support Plan in emergency situations must:

(a) Be reviewed by the Executive Director or the designee of the Executive Director within one hour of application;

(b) Be only used until the individual is no longer an immediate threat to self or others;

(c) Result in the submission of an incident report to the case manager or other Department designee (if applicable) and the legal or designated representative of the individual (if applicable), no later than one business day after the incident has occurred ; and

(d) Prompt an ISP meeting if emergency protective physical intervention is used more than three times in a six month period.

(5) Any use of protective physical intervention must be documented in an incident report, excluding circumstances described in section (7) of this rule. The report must include:

(a) The name of the individual to whom the protective physical intervention was applied;

(b) The date, type, and length of time the protective physical intervention was applied;

(c) A description of the incident precipitating the need for the use of protective physical intervention;

(d) Documentation of any injury;

(e) The name and the position of the staff member applying the protective physical intervention;

(f) The name and position of any staff member witnessing the protective physical intervention;

(g) The name and position of the person providing the initial review of the use of the protective physical intervention; and

(h) Documentation of a review by the Executive Director or the designee of the Executive Director who is knowledgeable in OIS, as evident by a job description that reflects this responsibility. The review must include the follow-up to be taken to prevent a recurrence of the incident.

(6) A copy of the incident report must be sent or made electronically available within five business days of the incident to the case manager and the legal or designated representative of the individual (when applicable).

(a) The case manager or the Department designee (when applicable) must receive complete copies of incident reports.

(b) Copies of incident reports may not be provided to a legal representative or other provider when the report is part of an abuse or neglect investigation.

(c) Copies sent or made electronically available to a legal representative or other provider must have confidential information about other individuals removed or redacted as required by federal and state privacy laws.

(d) All protective physical interventions resulting in injuries must be documented in an incident report and sent or made electronically available to the case manager or other Department designee (if applicable) within one business day of the incident.

(7) BEHAVIOR DATA SUMMARY.

(a) The provider may substitute a behavior data summary in lieu of individual incident reports when:

(A) There is no injury to the individual or others;

(B) There is a formal written functional behavioral assessment and a written Behavior Support Plan;

(C) The Behavior Support Plan defines and documents the parameters of the baseline level of behavior;

(D) The protective physical intervention techniques and the behavior for which the protective physical intervention techniques are applied remain within the parameters outlined in the Behavior Support Plan and OIS curriculum; and

(E) The behavior data collection system for recording observations, interventions, and other support information critical to the analysis of the efficacy of the Behavior Support Plan is also designed to record the items described in section (5)(a)-(c) and (e)-(h) of this rule.

(b) A copy of the behavior data summary must be forwarded or made electronically available every 30 days to the case manager or other Department designee (if applicable) and the legal or designated representative of the individual (if applicable).

Stat. Auth.: ORS 409.050 &430.662

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 309-041-0770 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0780

Psychotropic Medications and Medications for Behavior

(1) Psychotropic medications and medications for behavior must be prescribed by a physician through a written order.

(2) The use of psychotropic medications and medications for behavior must be based on the decision of a physician that the harmful effects without the medication clearly outweigh the potentially harmful effects of the medication. Providers must present the physician with a full and clear written description of the behavior and symptoms to be addressed, as well as any side effects observed, to enable the physician to make this decision.

(3) Psychotropic medications and medications for behavior must be:

(a) Monitored by the prescribing physician, ISP team, and provider for desired responses and adverse consequences; and

(b) Reviewed to determine the continued need and lowest effective dosage in a carefully monitored program.

Stat. Auth.: ORS 409.050 &430.662

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 309-041-0780 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 23-2016, f. & cert. ef. 6-29-16

411-328-0790

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. An individual who enters supported living is subject to eligibility as described in this section. To be eligible for supported living, an individual must:

(a) Be an Oregon resident;

(b) Be receiving a Medicaid Title XIX (OHP) benefit package through OSIPM or OCCS medical program. Individuals receiving Medicaid OHP under OCCS medical coverage for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(A) The transfer of assets as set forth in OAR 461-140-0210 to 461-140-0300; and

(B) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(c) Be determined eligible for developmental disability services by the CDDP of the county of origin as described in OAR 411-320-0080;

(d) Meet the level of care as defined in OAR 411-320-0020;

(e) Be an individual who is not receiving other Department-funded in-home or community living support;

(f) Have access to the financial resources to afford living expenses, such as food, utilities, rent, and other housing expenses; and

(g) Be eligible for Community First Choice state plan services.

(3) ENTRY.

(a) A provider must participate in an entry meeting prior to the onset of services to an individual.

(b) Prior to or upon an entry ISP team meeting, a provider must demonstrate effort to acquire the following individual information from the referring case management entity:

(A) A copy of the eligibility determination document;

(B) A statement indicating safety skills, including the ability of the individual 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 any behavioral challenges, including supervision and support needs;

(D) A medical history and information on health care supports that includes (when available):

(i) The results of the most recent physical exam;

(ii) The 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 recent needs assessment. If the needs of the individual have changed over time, the previous needs assessments must also be provided;

(G) Copies of protocols, the risk tracking record, and any support documentation (if available);

(H) Copies of documents relating to the guardianship, conservatorship, health care representation, power of attorney, court orders, probation and parole information, or any other legal restriction on the rights of the individual (if applicable);

(I) Written documentation to explain why preferences or choices of the individual may not be honored at that time;

(J) A copy of the most recent ISP or Service Agreement, Behavior Support Plan, and assessment (if available);

(K) Information related to the lifestyle, activities, and other choices and preferences; and

(L) Documentation of financial resources.

(4) VOLUNTARY TRANSFERS AND EXITS.

(a) A provider must promptly notify the case manager if an individual or the legal or designated representative of the individual gives notice of the intent to exit or abruptly exits services.

(b) A provider must notify the case manager prior to the voluntary transfer or exit of an individual from services.

(c) Notification and authorization of the voluntary transfer or exit of the individual must be documented in the record for the individual.

(5) INVOLUNTARY REDUCTIONS, TRANSFERS, AND EXITS.

(a) A provider must only reduce, transfer, or exit an individual involuntarily for one or more of the following reasons:

(A) The behavior of the individual poses an imminent risk of danger to self or others;

(B) The individual experiences a medical emergency;

(C) The service needs of the individual exceed the ability of the provider;

(D) The individual fails to pay for services; or

(E) The certification or endorsement for the provider described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) NOTICE OF INVOLUNTARY REDUCTION, TRANSFER, OR EXIT. A provider must not reduce services, transfer, or exit an individual involuntarily without 30 days advance written notice to the individual, the legal or designated representative of the individual (as applicable), and the

case manager, 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 the Notice of Involuntary Reduction, Transfer, or Exit form approved by the Department and include:

(i) The reason for the reduction, transfer, or exit; and

(ii) The right of the individual to a hearing as described in subsection (d) of this section.

(B) A Notice of Involuntary Reduction, Transfer, or Exit is not required when an individual requests the reduction, transfer, or exit.

(c) A provider may give less than 30 days advance 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, the legal or designated representative of the individual (as applicable), and the case manager immediately upon determination of the need for a reduction, transfer, or exit.

(d) HEARING RIGHTS. An individual must be given the opportunity for a hearing under ORS Chapter 183 and OAR 411-318-0030 to dispute an involuntary reduction, transfer, or exit. If an individual or the legal or designated representative of the individual 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 advance written notice of a reduction, transfer, or exit as described in subsection (c) of this section and the individual has requested a hearing, the provider must reserve service availability for the individual until receipt of the Final Order.

(6) EXIT MEETING. A provider must participate in an exit meeting before any decision to exit an individual is made if required by the case management entity.

(7) TRANSFER MEETING.A provider must participate in a transfer meeting before any decision to transfer an individual is made if required by the case management entity.

Stat. Auth.: ORS 409.050 &430.662

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; SPD 59-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 33-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 23-2016, f. & cert. ef. 6-29-16

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Rules Amended: 411-325-0010, 411-325-0020, 411-325-0025, 411-325-0030, 411-325-0040, 411-325-0110, 411-325-0130, 411-325-0140, 411-325-0150, 411-325-0170, 411-325-0220, 411-325-0270, 411-325-0280, 411-325-0290, 411-325-0300, 411-325-0390, 411-325-0410, 411-325-0430, 411-325-0460

Rules Repealed: 411-325-0420

Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the rules in OAR chapter 411, division 325 for 24-hour residential programs for children and adults with intellectual or developmental disabilities.

These rules are being updated to:

- Make permanent temporary changes that became effective on January 1, 2016;

- Provide consistency across services by removing terms included in the general definitions rule, OAR 411-317-0000;

- Incorporate the adoption of the rules for home and community-based (HCB) services and settings and person-centered service planning in OAR chapter 411, division 004;

- Incorporate the individual rights in OAR 411-318-0010 for individuals receiving HCB services;

- Incorporate the changes addressed in OAR chapter 411, division 450 for Community Living Supports, including information regarding entry, exit, and transfer notices, expectations around transfer of assets, and removal of crisis services; and

- Reflect current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

The rules in OAR chapter 411, division 004 implement the regulations and expectations of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) by providing a foundation of standards to support the network of Medicaid-funded and private pay residential and non-residential HCB services and settings and person-centered service planning.

Under the HCB setting standards, 24-hour residential settings meet the definition of a provider owned, controlled, or operated residential setting. A provider initially licensed on or after January 1, 2016 must meet the requirements in OAR chapter 411, division 004 prior to being licensed. A provider licensed prior to January 1, 2016 must make measurable progress toward compliance with the rules in OAR chapter 411, division 004 and be in full compliance by September 1, 2018.

By September 1, 2018, all provider owned, controlled, or operated residential settings must have all the following qualities:

- The setting is integrated in and supports the same degree of access to the greater community as people not receiving HCB services, including opportunities for individuals enrolled in or utilizing HCB services to seek employment and work in competitive integrated employment settings, engage in greater community life, control personal resources, and receive services in the greater community;

- The setting is selected by an individual, or as applicable the legal or designated representative of the individual, from among available setting options, including non-disability specific settings and an option for a private unit in a residential setting;

- The setting ensures individual rights of privacy, dignity, respect, and freedom from coercion and restraint;

- The setting optimizes, but does not regiment, individual initiative, autonomy, self-direction, and independence in making life choices including, but not limited to, daily activities, physical environment, and with whom to interact;

- The setting facilitates individual choice regarding services and supports, and who provides the services and supports;

- The setting is physically accessible to an individual;

- The unit is a specific physical place that may be owned, rented, or occupied by an individual under a legally enforceable Residency Agreement;

- Each individual has privacy in his or her own unit;

- Units have entrance doors lockable by the individual, with the individual and only appropriate staff having a key to access the unit;

- Individuals sharing units have a choice of roommates;

- Individuals have the freedom to decorate and furnish his or her own unit as agreed to within the Residency Agreement;

- Individuals may have visitors of their choosing at any time;

- Each individual has the freedom and support to control his or her own schedule and activities; and

- Each individual has the freedom and support to have access to food at any time.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-325-0010

Statement of Purpose

(1) The rules in OAR chapter 411, division 325 prescribe standards, responsibilities, and procedures for 24-hour residential programs delivering home and community-based services to individuals with intellectual or developmental disabilities in 24-hour residential settings.

(2) These rules incorporate the provisions for home and community-based services and settings and person-centered service planning set forth in OAR chapter 411, division 004. These rules and the rules in OAR chapter 411, division 004 ensure individuals with intellectual or developmental disabilities receive services in settings that are integrated in and support the same degree of access to the greater community as people not receiving home and community-based services.

(a) A provider initially licensed on or after January 1, 2016 must meet the requirements in OAR chapter 411, division 004 prior to being licensed.

(b) A provider licensed prior to January 1, 2016 must make measurable progress toward compliance with the rules in OAR chapter 411, division 004 and be in full compliance by September 1, 2018.

Stat. Auth.: ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16l APD 24-2016, f. & cert. ef. 6-29-16

411-325-0020
Definitions and Acronyms

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 325:

(1) "24-Hour Residential Program" means the distinct method for the delivery of home and community-based services in a 24-hour residential setting by a provider certified and endorsed under the rules in OAR chapter 411, division 323.

(2) "24-Hour Residential Setting" means a residential home, apartment, or duplex licensed by the Department under ORS 443.410 in which home and community-based services are provided to individuals with intellectual or developmental disabilities. A 24-hour residential setting is considered a provider owned, controlled, or operated residential setting.

(3) "Apartment" means "24-hour residential setting" as defined in this rule.

(4) "Appeal" means the process under ORS Chapter 183 that a provider may use to petition a civil penalty.

(5) "Applicant" means a person, agency, corporation, or governmental unit who applies for a license to deliver home and community-based services in a 24-hour residential setting.

(6) "Board of Directors" means the group of people formed by the provider agency to set policy and give directions to a provider delivering supports to individuals in a community-based service setting. A board of directors may include local advisory boards used by multi-state organizations.

(7) "CDDP" means "Community Developmental Disabilities Program".

(8) "Certificate" means the document issued by the Department to a provider that certifies the provider is eligible under the rules in OAR chapter 411, division 323 to receive state funds for the delivery of services through an endorsed 24-hour residential program.

(9) "Competency Based Training Plan" means the written description of the process of the provider 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 mission of the provider; 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 provider to accommodate the specific circumstances of a staff member.

(10) "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 provider.

(11) "Denial" means the refusal of the Department to issue a certificate, endorsement, or license to operate a 24-hour residential program or 24-hour residential setting because the Department has determined the provider or the home is not in compliance with these rules or the rules in OAR chapter 411, division 323.

(12) "Duplex" means "24-hour residential setting" as defined in this rule.

(13) "Educational Surrogate" means the person who acts in place of the parent of a child in safeguarding the rights of the child in the public education decision-making process:

(a) When the parent of the child 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 of the child or young adult student.

(14) "Endorsement" means the authorization to provide services in a 24-hour residential setting that is issued by the Department to a certified provider that has met the qualification criteria outlined in these rules and the rules in OAR chapter 411, division 323.

(15) "Executive Director" means the person designated by a board of directors or corporate owner responsible for the operation of a 24-hour residential program and the administration of services in a 24-hour residential setting.

(16) "Functional Needs Assessment":

(a) Means the comprehensive assessment or re-assessment that:

(A) Documents physical, mental, and social functioning;

(B) Identifies risk factors and support needs; and

(C) Determines the service level.

(b) A functional needs assessment may be:

(A) The Support Needs Assessment Profile (SNAP). The Department incorporates the SNAP into these rules by this reference. The SNAP is maintained by the Department at https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/PROVIDERS-PARTNERS/Pages/rebar-assessments.aspx;

(B) The Supports Intensity Scale (SIS). The Department incorporates the SIS into these rules by this reference. The SIS is maintained at: http://aaidd.org/sis#.VvwgeaPn_Dc;

(C) The Adult Needs Assessment (ANA). The Department incorporates Version C of the ANA into these rules by this reference. The ANA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm; or

(D) The Children's Needs Assessment (CNA). The Department incorporates Version C of the CNA into these rules by this reference. The CNA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm.

(c) A printed copy of the assessment tools may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

(17) "Home" means "24-hour residential setting" as defined in this rule.

(18) "ICF/ID" means "Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities".

(19) "ISP" means "Individual Support Plan".

(20) "License" means a document granted by the Department to an applicant who is in compliance with the requirements of these rules and the rules in OAR chapter 411, division 323.

(21) "Licensee" means the person or organization to whom a certificate, endorsement, and license is granted.

(22) "Modified Diet" means the texture or consistency of food or drink is altered or limited, such as no nuts or raw vegetables, thickened fluids, mechanical soft, finely chopped, pureed, or bread only soaked in milk.

(23) "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. Nursing services differ from administrative nursing services.

(24) "OCCS" means the "Oregon Health Authority, Office of Client and Community Services".

(25) "OIS" means "Oregon Intervention System".

(26) "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 mission of the provider; and

(b) The associated timelines in which newly hired staff must demonstrate the competencies.

(27) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(28) "Revocation" means the action taken by the Department to rescind a certificate, endorsement, or license to operate a 24-hour residential program or 24-hour residential setting after the Department determines a provider or home is not in compliance with these one or more of these rules or the rules in OAR chapter 411, division 323.

(29) "Special Diet" means the specially prepared food or particular types of food that are specific to the medical condition or diagnosis of an individual and in support of an evidence-based treatment regimen. Examples include, but are not limited to, low calorie, high fiber, diabetic, low salt, lactose free, or low fat diets. A special diet does not include a diet where extra or additional food is offered without the order of a physician, but may not be eaten, such as offering prunes each morning at breakfast or including fresh fruit with each meal.

(30) "Suspension" means an immediate temporary withdrawal of the approval to operate a 24-hour residential program or 24-hour residential setting after the Department determines a provider or home is not in compliance with one or more of these rules or the rules in OAR chapter 411, division 323.

(31) "These Rules" mean the rules in OAR chapter 411, division 325.

(32) "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 provider.

Stat. Auth.: ORS 409.050, 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; SPD 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0025
Program Management

(1) CERTIFICATION, ENDORSEMENT, AND ENROLLMENT. To operate a 24-hour residential program, a provider must have:

(a) A certificate and an endorsement for a 24-hour residential program as set forth in OAR chapter 411, division 323;

(b) A Medicaid Agency Identification Number assigned by the Department as described in OAR chapter 411, division 370; and

(c) For each specific geographic service area where 24-hour residential services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.

(2) INSPECTIONS AND INVESTIGATIONS. The provider must allow inspections and investigations as described in OAR 411-323-0040.

(3) MANAGEMENT AND PERSONNEL PRACTICES. The provider must comply with the management and personnel practices as described in OAR 411-323-0050.

(4) COMPETENCY BASED TRAINING PLAN. The provider must have and implement a Competency Based Training Plan that meets, at a minimum, the competencies and timelines set forth in the Department's Oregon Core Competencies.

(5) GENERAL STAFF QUALIFICATIONS. Any staff member providing direct assistance to individuals must:

(a) Have knowledge of the ISPs for all individuals and all medical, behavioral, and additional supports required by the individuals; and

(b) Have met the basic qualifications in the Competency Based Training Plan. The provider must maintain written documentation kept current that the staff member has demonstrated competency in areas identified by the Competency Based Training Plan as required by section (4) of this rule, and that is appropriate to their job description.

(6) CONFIDENTIALITY OF RECORDS. The provider must ensure all individuals' records are confidential as described in OAR 411-323-0060.

(7) DOCUMENTATION REQUIREMENTS. All entries required by these rules, unless stated otherwise must:

(a) Be prepared at the time, or immediately following the event being recorded;

(b) Be accurate and contain no willful falsifications;

(c) Be legible, dated, and signed by the person making the entry; and

(d) Be maintained for no less than three years.

Stat. Auth. ORS 409.050, 410.070, 443.450, & 443.455
Stats. Implemented: ORS 443.400 - 443.455
Hist.: SPD 19-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 1-2012, f. & cert. ef. 1-6-12; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0030
Issuance of License

(1) No person, agency, or governmental unit acting individually or jointly with any other person, agency, or governmental unit shall establish, conduct, maintain, manage, or operate a 24-hour residential program without being licensed for each 24-hour residential setting.

(2) No license is transferable or applicable to any location, home, agency, management agent, or ownership other than that indicated on the application and license.

(3) The Department issues a license to an applicant found to be in compliance with these rules. The license is in effect for two years from the date issued unless revoked or suspended.

Stat. Auth.: ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0040
Application for Initial License

(1) At least 30 days prior to anticipated licensure, an applicant must submit an application and required non-refundable fee. The application is provided by the Department and must include all information requested by the Department.

(2) The application must identify the number of beds the 24-hour residential setting is presently capable of operating at the time of application, considering existing equipment, ancillary service capability, and the physical requirements as specified by these rules. For purposes of license renewal, the number of beds to be licensed may not exceed the number identified on the license to be renewed unless approved by the Department.

(3) The initial application must include:

(a) A copy of any lease agreements or contracts, management agreements or contracts, and sales agreements or contracts, relative to the operation and ownership of the home;

(b) A floor plan of the home showing the location and size of rooms, exits, smoke alarms, and extinguishers; and

(c) A copy of the Residency Agreement as described in OAR 411-325-0300.

(4) If a scheduled, onsite licensing inspection reveals that an applicant is not in compliance with these rules as attested to on the Licensing Onsite Inspection Checklist, the onsite licensing inspection may be rescheduled at the convenience of the Department.

(5) Applicants may not admit any individual to the home prior to receiving a written confirmation of licensure from the Department.

(6) If an applicant fails to provide complete, accurate, and truthful information during the application and licensing process, the Department may cause initial licensure to be delayed or may deny or revoke the license.

(7) Any applicant or person with a controlling interest in an agency is considered responsible for acts occurring during, and relating to, the operation of such home for the purpose of licensing.

(8) The Department may consider the background and operating history of each applicant and each person with a controlling ownership interest when determining whether to issue a license.

(9) When an application for initial licensure is made by an applicant who owns or operates other licensed homes or facilities in Oregon, the Department may deny the license if the applicant's existing home or facility is not, or has not been, in substantial compliance with the Oregon Administrative Rules.

(10) Separate licenses are not required for separate buildings located contiguously and operated as an integrated unit by the same management.

(11) A provider may not admit an individual whose service needs exceed the classification on the license of the home without prior written consent of the Department.

Stat. Auth.: ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0110
Variances

(1) The Department may grant a variance to these rules based upon a demonstration by the provider that an alternative method or different approach provides equal or greater effectiveness and does not adversely impact the welfare, health, safety, or rights of the individuals or violate state or federal laws.

(2) The provider requesting a variance must submit a written application to the CDDP that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept, or procedure proposed; and

(d) If the variance applies to the services for an individual, evidence that the variance is consistent with the currently authorized ISP for the individual.

(3) The request for a variance is approved or denied by the Department. The decision of the Department is sent to the provider, the CDDP, and to all relevant Department programs or offices within 30 days from the receipt of the variance request.

(4) The provider may request an administrative review of the denial of a variance request. The Department must receive a written request for an administrative review within 10 business days from the receipt of the denial. The provider must send a copy of the written request for an administrative review to the CDDP. The decision of the Director is the final response from the Department.

(5) The duration of the variance is determined by the Department.

(6) The provider may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 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 1-2012, f. & cert. ef. 1-6-12; SPD 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0130
Food and Nutrition

(1) The provider must support the freedom of the resident to have access to his or her personal food at any time. Limitations may only be used when there is a health or safety risk, as described in OAR 411-325-0430 and 411-004-0040, and when a written informed consent is obtained.

(2) Three nutritious meals and two snacks must be provided. Meals must be offered daily at times consistent with those in the community.

(a) Each meal must include food from the basic food groups according to the United States Department of Agriculture (USDA) and include fresh fruit and vegetables when in season, unless otherwise specified in writing by a physician.

(b) Food preparation must include consideration of cultural and ethnic backgrounds, as well as, the food preferences of individuals. Special consideration must be given to individuals with chewing difficulties and other eating limitations as described in section (3) of this rule.

(c) If an individual misses or plans to miss a meal at a scheduled time, or requests an alternate mealtime, an alternative meal must be made available. Individuals are not restricted to specific mealtimes and are encouraged to choose when, where, and with whom to eat.

(d) Provision of food beyond the required three meals and two snacks are the responsibility of the individual.

(3) MODIFIED OR SPECIAL DIETS. For an individual with a physician or health care provider ordered modified or special diet, the provider must:

(a) Have menus for the current week that provide food and beverages that consider the preferences of the individual and are appropriate to the modified or special diet; and

(b) Maintain documentation that identifies how modified or special diets are prepared and served to individuals.

(4) Unpasteurized milk and juice or home canned meats and fish may not be served or stored in the home.

(5) Adequate supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days must be maintained on the premises.

(6) Food must be stored, prepared, and served in a sanitary manner.

Stat. Auth.: ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0140
Physical Environment

(1) All floors, walls, ceilings, windows, furniture, and fixtures must be kept in good repair, clean, and free from odors. Walls, ceilings, and floors must be of such character to permit frequent washing, cleaning, or painting.

(2) The interior and exterior must be well and safely maintained and accessible according to the needs of the individuals.

(3) The water supply and sewage disposal must meet the requirements of the current rules of the Oregon Health Authority governing domestic water supply.

(4) A public water supply must be utilized if available. If a non-municipal water source is used, a sample must be collected yearly by the provider, sanitarian, or a technician from a certified water-testing laboratory. The water sample must be tested for coliform bacteria and action taken to ensure potability. Test records must be retained for three years.

(5) Septic tanks or other non-municipal sewage disposal systems must be in good working order.

(6) Incontinence garments must be disposed of in closed containers.

(7) The temperature within the home must be maintained within a normal comfort range. During times of extreme summer heat, the provider must make reasonable effort to keep individuals comfortable using ventilation, fans, or air conditioning.

(8) Screening for workable fireplaces and open-faced heaters must be provided.

(9) All heating and cooling devices must be installed in accordance with current building codes and maintained in good working order.

(10) Handrails must be provided on all stairways.

(11) Yard and exterior steps must be accessible and appropriate to the needs of the individuals.

(12) Swimming pools, hot tubs, saunas, or spas must be equipped with safety barriers or devices designed to prevent accidental injury and unsupervised access.

(13) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards. Proof of current rabies vaccinations and any other vaccinations that are required for the pet by a licensed veterinarian must be maintained on the premises. Pets not confined in enclosures must be under control and may not present a danger or health risk to individuals or guests.

(14) All measures necessary must be taken to prevent the entry of rodents, flies, mosquitoes, and other insects.

(15) The interior and exterior of the residence must be kept free of litter, garbage, and refuse.

(16) Any work undertaken at a residence, including, but not limited to demolition, construction, remodeling, maintenance, repair, or replacement must comply with all applicable state and local building, electrical, plumbing, and zoning codes appropriate to the individuals served.

(17) Providers must comply with all applicable legal zoning ordinances pertaining to the number of individuals receiving services at the home.

Stat. Auth.: ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0150
General Safety

(1) All toxic materials, including, but not limited to poisons, chemicals, rodenticides, and insecticides must be:

(a) Properly labeled;

(b) Stored in the original container separate from all foods, food preparation utensils, linens, and medications; and

(c) Stored in a locked area unless the Risk Tracking records for all individuals residing in the home document that there is no risk present.

(2) All flammable and combustible materials must be properly labeled, stored, and locked in accordance with state fire code.

(3) For children, knives and sharp kitchen utensils must be locked unless otherwise determined by a documented ISP team decision.

(4) Window shades, curtains, or other covering devices must be provided for all bedroom and bathroom windows to assure privacy.

(5) Hot water in bathtubs and showers may not exceed 120 degrees Fahrenheit. Other water sources, except the dishwasher, may not exceed 140 degrees Fahrenheit.

(6) Bedrooms.

(a) Bedrooms on ground level must have at least one window that opens from the inside without special tools that provides a clear opening of not less than 821 square inches, with the least dimension not less than 22 inches in height or 20 inches in width. Sill height may not be more than 44 inches from the floor level. Exterior sill heights may not be greater than 72 inches from the ground, platform, deck, or landing. There must be stairs or a ramp to ground level. Those homes previously licensed having a minimum window opening of not less than 720 square inches are acceptable unless through inspection it is deemed that the window opening dimensions present a life safety hazard.

(b) Bedrooms must have 60 square feet per individual with beds located at least three feet apart.

(c) If an individual chooses to share a bedroom with another individual, the individuals must be afforded an opportunity to have a choice of roommates.

(d) Single Action Locks.

(A) A 24-hour residential setting licensed on or after January 1, 2016 must have single action locks on the entrance doors to the bedroom for each individual, lockable by the individual, with only appropriate staff having keys.

(B) A 24-hour residential setting licensed prior to January 1, 2016 must have single action locks on the entrance doors to the bedroom for each individual, lockable by the individual, with only appropriate staff having keys by September 1, 2018.

(C) Limitations may only be used when there is a health or safety risk and when a written informed consent is obtained as described in OAR 411-325-0430 and 411-004-0040.

(7) Operative flashlights, at least one per floor, must be readily available to staff in case of emergency.

(8) First-aid kits and first-aid manuals must be available to staff within each home in a designated location. First aid kits must be locked if, after evaluating any associated risk, items contained in the first aid kit present a hazard to individuals living in the home. First aid kits containing any medication including topical medications must be locked.

Stat. Auth.: ORS 409.050, 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 1-2012, f. & cert. ef. 1-6-12; SPD 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0170
Staffing Requirements

(1) Each residence must provide staff appropriate to the number of individuals served as follows:

(a) Each home serving five or fewer individuals must provide at a minimum one staff on the premises when individuals are present;

(b) Each home serving five or fewer individuals in apartments must provide at a minimum one staff on the premises of the apartment complex when individuals are present;

(c) Each home serving six or more individuals must provide a minimum of one staff on the premises for every 15 individuals during awake hours and one staff on the premises for every 15 individuals during sleeping hours, except residences licensed prior to January 1, 1990; and

(d) Each home serving children, for any number of children, must provide at a minimum one awake night staff on the premises when children are present.

(2) A home is granted an exception to the staffing requirements in sections (1)(a), (1)(b), and (1)(c) for adults to be home alone when the following conditions have been met:

(a) No more than two adults are to be left alone in the home at any time without on-site staff supervision;

(b) The amount of time any adult individual may be left alone may not exceed five hours within a 24-hour period and an adult individual may not be responsible for any other adult individual or child in the home or community;

(c) An adult individual may not be left home alone without staff supervision between the hours of 11:00 P.M. and 6:00 A.M.;

(d) The adult individual has a documented history of being able to do the following safety measures or there is a documented ISP team decision agreeing to an equivalent alternative practice:

(A) Independently call 911 in an emergency and give relevant information after calling 911;

(B) Evacuate the premises during emergencies or fire drills without assistance in three minutes or less;

(C) Knows when, where, and how to contact the provider in an emergency;

(D) Before opening the door, check who is there;

(E) Answer the door appropriately;

(F) Use or understands to not use small appliances, sharp knives, kitchen stove, and microwave safely if not used safely;

(G) Self-administer medications, if applicable;

(H) Safely adjust water temperature at all faucets; and

(I) Safely take a shower or bathe without falling.

(e) There is a documented ISP team decision annually noting team agreement that the adult individual meets the requirements of subsection (d) of this section.

(3) If at any time an adult individual is unable to meet the requirements in section (2)(d)(A)–(I) of this rule, the provider may not leave the adult individual alone without supervision. In addition, the provider must notify services coordinator for the adult individual within one working day and request that the ISP team meet to address the ability of the adult individual to be left alone without supervision.

(4) Each home must meet all requirements for staff ratios as specified by contract requirements.

Stat. Auth.: ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0220
Individual Furnishings

(1) Bedroom furniture must be provided or arranged for each individual and include:

(a) A bed including a frame unless otherwise documented by an ISP team decision, a clean comfortable mattress, a waterproof mattress cover if the individual is incontinent, and a pillow;

(b) A private dresser or similar storage area for personal belongings that is readily accessible to the individual; and

(c) A closet or similar storage area for clothing that is readily accessible to the individual.

(2) Individuals must have the freedom to decorate and furnish his or her own bedroom as agreed to within the Residency Agreement.

(3) Two sets of linens must be provided or arranged for each individual and include:

(a) Sheets and pillowcases;

(b) Blankets appropriate in number and type for the season and the comfort of the individual; and

(c) Towels and washcloths.

(4) Each individual must be assisted in obtaining personal hygiene items in accordance with individual needs and items must be stored in a sanitary and safe manner.

Stat. Auth.: ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0270
Fire Safety Requirements for Homes on a Single Property or on Contiguous Property Serving Six or More Individuals

(1) The home must provide safety equipment appropriate to the number and level of individuals served and meet the requirements of the State of Oregon Structural Specialty and Fire Code as adopted by the state:

(a) Each home housing six or more, but fewer than 11 individuals or each home that houses five or fewer individuals, but is licensed as a single facility due to the total number of individuals served per the license or meets the contiguous property provision, must meet the requirements of a SR 3.3 occupancy and must:

(A) Provide and maintain permanent wired smoke alarms from a commercial source with battery back-up in each bedroom and at a point centrally located in the corridor or area giving access to each separate sleeping area and on each floor;

(B) Provide and maintain a 13D residential sprinkler system as defined in the National Fire Protection Association standard; and

(C) Have simple hardware for all exit doors and interior doors that may not be locked against exit that has an obvious method of operation. Hasps, sliding bolts, hooks and eyes, double key deadbolts, and childproof doorknobs are not permitted. Any other deadbolts must be single action release so as to allow the door to open in a single operation.

(b) Each home housing 11 or more, but fewer than 17 individuals must meet the requirements of a SR 3.2 occupancy.

(c) Each home housing 17 or more individuals must meet the requirements of a SR 3.1 occupancy.

(2) The number of individuals receiving services may not exceed the licensed capacity, except that one additional individual at a time may receive community living supports. Community living supports may not violate the safety and health sections of these rules. Relief care may not be provided to any individual for more than 14 consecutive days.

(3) The provider may not admit individuals functioning below the level indicated on the license for the home.

Stat. Auth. ORS 409.050, 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 11-2008, f. & cert. ef. 9-11-08; SPD 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0280
Fire Safety Requirements for Homes or Duplexes Serving Five or Fewer Individuals

(1) The home or duplex must be made fire safe.

(a) A second means of egress must be provided.

(b) A class 2A10BC fire extinguisher that is easily accessible must be provided on each floor in the home or duplex.

(c) Permanent wired smoke alarms from a commercial source with battery back up in each bedroom and at a point centrally located in the corridor or area giving access to each separate sleeping area and on each floor must be provided and maintained.

(d) A 13D residential sprinkler system in accordance with the National Fire Protection Association Code must be provided and maintained. Homes or duplexes rated as "Prompt" facilities per Chapter 3 of the 2000 edition NFPA 101 Life Safety Code are granted an exception from the residential sprinkler system requirement.

(e) Hardware for all exit doors and interior doors must be simple hardware that may not be locked against exit and must have an obvious method of operation. Hasp, sliding bolts, hooks and eyes, double key deadbolts, and childproof doorknobs are not permitted. Any other deadbolts must be single action release so as to allow the door to open in a single operation.

(2) A home or duplex is granted an exception to the requirements in sections (1)(c) and (d) of this rule under the following circumstances:

(a) All individuals residing in the home or duplex have demonstrated the ability to respond to an emergency alarm with or without physical assistance from staff to the exterior and away from the home or duplex in three minutes or less, as evidenced by three or more consecutive documented fire drills;

(b) Battery operated smoke alarms with a 10 year battery life and hush feature have been installed in accordance with the manufacturer's listing, in each bedroom, adjacent hallways, common living areas, basements, and in two-story homes or duplexes at the top of each stairway. Ceiling placement of smoke alarms is recommended. If wall mounted, smoke alarms must be mounted as per the manufacturer's instructions. Alarms must be equipped with a device that warns of low battery condition when battery operated. All smoke alarms are to be maintained in functional condition; and

(c) A written fire safety evacuation plan is implemented that assures that staff assist all individuals in evacuating the premises safely during an emergency or fire as documented by fire drill records.

(3) The number of individuals receiving services at the home or duplex may not exceed the maximum capacity of five individuals, including an individual receiving community living supports. Relief care may not be provided to any individual for more than 14 consecutive days. Community living supports may not violate the safety and health sections of these rules.

Stat. Auth. ORS 409.050, 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 11-2008, f. & cert. ef. 9-11-08; SPD 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0290
Fire Safety Requirements for Apartments Serving Five or Fewer Individuals

(1) The apartment must be made fire safe by:

(a) Providing and maintaining in each apartment, battery-operated smoke alarms with a 10-year life in each bedroom and in a central location on each floor;

(b) Providing first floor occupancy apartments. Individuals who are able to exit in three minutes or less without assistance may be granted a variance from the first floor occupancy requirement;

(c) Providing a class 2A10BC portable fire extinguisher easily accessible in each apartment;

(d) Providing access to telephone equipment or intercom in each apartment usable by the individual receiving services; and

(e) Providing constantly usable unblocked exits from the apartment and apartment building.

(2) The number of individuals receiving services at the apartment may not exceed the maximum capacity of five individuals, including an individual receiving community living supports. Relief care may not be provided to any individual for more than 14 consecutive days. Community living supports may not violate the safety and health sections of these rules.

Stat. Auth. ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0300
Residency Agreements, Individual Rights, Complaints, Notification of Planned Action, and Hearings

(1) RESIDENCY AGREEMENTS.

(a) The provider must enter into a written Residency Agreement with each individual specifying, at a minimum, the following:

(A) The rights and responsibilities of the individual and the provider; and

(B) The eviction process, notice requirements, and appeal rights available to each individual.

(b) The Residency Agreement may not violate the rights of an individual as stated in OAR 411-318-0010.

(c) The Residency Agreement may not be in conflict with any of these rules, the certification and endorsement rules in OAR chapter 411, division 323, or the home and community-based services and settings rules in OAR chapter 411, division 004.

(d) Prior to implementing changes to the Residency Agreement, the Residency Agreement may be subject to review by the Department or the designee of the Department.

(e) The provider must review and provide a copy of the Residency Agreement to each individual and the legal representative of the individual, as applicable, at the time of entry and annually or as changes occur. The reviews must be documented by having the individual, or the legal representative of the individual, sign and date a copy of the Residency Agreement. A copy of the signed and dated Residency Agreement must be maintained in the record for the individual.

(2) INDIVIDUAL RIGHTS.

(a) A provider must protect the rights of individuals described in OAR 411-318-0010 and encourage and assist individuals to understand and exercise these rights.

(b) Upon entry and request and annually thereafter, the individual rights described in OAR 411-318-0010 must be provided to an individual and the legal or designated representative of the individual.

(c) The individual rights apply to all individuals eligible for or receiving developmental disabilities services. A parent or guardian may place reasonable limitations on the rights of a child.

(3) COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015.

(b) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(4) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disability service is denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(5) HEARINGS.

(a) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(b) An individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025 for a denial, reduction, suspension, or termination or OAR 411-318-0030 for an involuntary reduction, transfer, or exit.

(c) Upon entry and request and annually thereafter, a notice of hearing rights and the policy and procedures for hearings must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

Stat. Auth.: ORS 409.050, 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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0390
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. An individual who enters a 24-hour residential setting is subject to eligibility as described in this section.

(a) To be eligible for services in a 24-hour residential setting, an individual must:

(A) Be an Oregon resident;

(B) Be eligible for OCCS Medical;

(C) Be determined eligible for:

(i) Developmental disability services by the CDDP of the county of origin as described in OAR 411-320-0080; or

(ii) Services for Aging and People with Disabilities as described in OAR chapter 411, division 015.

(D) Meet the level of care for an ICF/ID, nursing facility, or hospital; and

(E) Be an individual who is not receiving other Department-funded in-home or community living support.

(b) Individuals receiving Medicaid Title XIX (OHP) under OCCS medical coverage for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(A) The transfer of assets as set forth in OAR 461-140-0210 to 461-140-0300; and

(B) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(3) ENTRY.

(a) ENTRY MEETING. A provider must participate in an entry meeting prior to the onset of services to an individual.

(b) Prior to or upon an entry, a provider must demonstrate efforts to acquire the following individual information from the referring CDDP:

(A) A copy of the eligibility determination document;

(B) A statement indicating the safety skills, including the ability of the individual 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 any behavioral challenges, including supervision and support needs;

(D) A medical history and information on health care supports that includes (when available):

(i) The results of the most recent physical exam;

(ii) The 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 recent needs assessment. If the needs of the individual have changed over time, the previous needs assessments must also be provided;

(G) Copies of protocols, the risk tracking record, and any support documentation (if available);

(H) Copies of documents relating to the guardianship, conservatorship, health care representation, power of attorney, court orders, probation and parole information, or any other legal restrictions on the rights of the individual (if applicable);

(I) Written documentation that the individual is participating in out of residence activities, including public school enrollment for individuals less than 21 years of age;

(J) Written documentation to explain why preferences or choices of the individual may not be honored at that time; and

(K) A copy of the most recent Behavior Support Plan and assessment, ISP or Service Agreement, Nursing Service Plan, and Individualized Education Program (if available).

(c) If an individual is being admitted from the family home of the individual and the information required in subsection (b) of this section is not available, the 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. The plan must include a written justification as to why the information is not available.

(4) VOLUNTARY TRANSFERS AND EXITS.

(a) A provider must promptly notify a services coordinator if an individual gives notice of the intent to exit or abruptly exits services.

(b) A provider must notify a services coordinator prior to the voluntary transfer or exit of an individual from services.

(c) Notification and authorization of the voluntary transfer or exit of the individual must be documented in the record for the individual.

(d) A provider is responsible for the provision of services until an individual exits the home.

(5) INVOLUNTARY REDUCTIONS, TRANSFERS, AND EXITS.

(a) A provider must only reduce, transfer, or exit an individual involuntarily for one or more of the following reasons:

(A) The behavior of the individual poses an imminent risk of danger to self or others;

(B) The individual experiences a medical emergency;

(C) The service needs of the individual exceed the ability of the provider;

(D) The individual fails to pay for services; or

(E) The certification or endorsement for the provider described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered or the license for the home is suspended, revoked, not renewed, or voluntarily surrendered.

(b) NOTICE OF INVOLUNTARY REDUCTION, TRANSFER, OR EXIT. A provider must not reduce services, transfer, or exit an individual involuntarily without 30 days advance written notice to the individual, the legal or designated representative of the individual (as applicable), and the 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 the Notice of Involuntary Reduction, Transfer, or Exit form approved by the Department and include:

(i) The reason for the reduction, transfer, or exit; and

(ii) The right of the individual to a hearing as described in subsection (e) of this section.

(B) A Notice of Involuntary Reduction, Transfer, or Exit is not required when an individual requests the reduction, transfer, or exit.

(c) A provider may give less than 30 days advance 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, the legal or designated representative of the individual (as applicable), and the services coordinator immediately upon determination of the need for a reduction, transfer, or exit.

(d) A 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 hearing under ORS chapter 183 and OAR 411-318-0030 to dispute an involuntary reduction, transfer, or exit. If an individual 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 advance written notice of a reduction, transfer, or exit as described in subsection (c) of this section and the individual has requested a hearing, the provider must reserve the room of the individual until receipt of the Final Order.

(6) EXIT MEETING. A provider must participate in an exit meeting before any decision to exit an individual is made if required by the case management entity.

(7) TRANSFER MEETING.A provider must participate in a transfer meeting before any decision to transfer an individual is made if required by the case management entity.

Stat. Auth.: ORS 409.050, 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 23-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13; SPD 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0410
Community Living Supports

(1) All individuals considered for community living supports must:

(a) Be referred by the CDDP, Brokerage, or Department; and

(b) 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) Relief care services may not be provided for more than 14 consecutive days to a single individual.

(3) Exit meetings are waived for individuals receiving community living supports.

(4) Individuals receiving community living supports do not have appeal rights regarding entry, exit, or transfer.

(5) A provider certified and endorsed under OAR chapter 411, division 323 to operate a 24-hour residential program does not require an endorsement under OAR chapter 411, division 450 to deliver community living supports when the community living supports are in or based out of a 24-hour residential setting licensed under these rules. Unless as part of a recreational outing, a provider endorsed to operate a 24-hour residential program may not deliver community living supports away from the licensed 24-hour residential setting.

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 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0430
Individual Support Plan

(1) The following information must be collected and summarized by the provider prior to an ISP meeting:

(a) One page profile reflecting, at a minimum, information gathered by the provider at the setting where the individual receives services;

(b) Person-centered Information reflecting, at a minimum, information gathered by the provider at the setting where the individual receives services; and

(c) Information about known, identified serious risks.

(2) The following information must be developed by the provider and shared with the case manager and the individual, or if applicable the legal or designated representative of the individual, as directed by the ISP or Service Agreement.

(a) Implementation strategies, such as action plans, for desired outcomes or goals.

(b) Necessary protocols or plans that address health, behavioral, safety, and financial supports.

(c) A summary of the provider risk management strategies in place, including title of document, date, and where the document is located.

(d) A Nursing Service Plan, if applicable.

(e) Other documents required by the ISP team.

(3) When desired by the individual, the provider must participate in the ISP team meetings.

(4) A provider must agree in writing to implement the portion of the ISP for which the provider is responsible for implementing. Agreement may be recorded by a signature on the ISP or a Service Agreement.

(5) The provider must maintain a copy of the ISP or Service Agreement provided the CDDP.

(6) The provider must maintain documentation of implementation of each support and services specified in sections (2)(a) to (2)(e) of this rule in the ISP for the individual. This documentation must be kept current and be available for review by the individual, the legal representative of the individual, CDDP, and Department representatives.

(7) Individually-Based Limitations.

(a) For an initial or annual ISP authorized to begin on or after March 1, 2017, the provider must identify any individually-based limitations to the following freedoms:

(A) Support and freedom to access the individual's personal food at any time;

(B) Visitors of the individual's choosing at any time;

(C) A lock on the individual's bedroom, lockable by the individual;

(D) Choice of a roommate, if sharing a bedroom;

(E) Freedom to furnish and decorate the individual's bedroom as the individual chooses in accordance with the Residency Agreement; and

(F) Freedom and support to control the individual's schedule and activities.

(b) All individually-based limitations must be included in the ISP no later than February 28, 2018.

(c) An individually-based limitation to any freedom in subsection (a) of this section must be supported by a specific assessed need due to threats to the health and safety of the individual or others. The provider must incorporate and document all applicable elements identified in OAR 411-004-0040, including:

(A) The specific and individualized assessed need justifying the individually-based limitation;

(B) The positive interventions and supports used prior to any individually-based limitation;

(C) Less intrusive methods that have been tried, but did not work;

(D) A clear description of the condition that is directly proportionate to the specific assessed need;

(E) Regular reassessment and review to measure the ongoing effectiveness of the individually-based limitation;

(F) Established time limits for periodic review of the individually-based limitation to determine if the individually-based limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually;

(G) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative; and

(H) An assurance that the interventions and support do not cause harm to the individual.

(8) The provider must maintain documentation of implementation of each support and services specified in the ISP or Service Agreement for the individual. This documentation must be kept current and be available for review by the individual, the legal representative of the individual, CDDP, and Department representatives.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400-455
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 1-2012, f. & cert. ef. 1-6-12; SPD 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 34-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 24-2016, f. & cert. ef. 6-29-16

411-325-0460
Civil Penalties

(1) For purposes of imposing civil penalties, 24-hour residential settings licensed under ORS 443.400 to 443.455 and 443.991(2) are considered to be long-term care facilities subject to ORS 441.705 to 441.745.

(2) The Department issues the following schedule of penalties applicable to 24-hour residential settings as provided for under ORS 441.705 to 441.745:

(a) Violations of any requirement within any part of the following rules may result in a civil penalty up to $500 per day for each violation not to exceed $6,000 for all violations for any licensed 24-hour residential setting within a 90-day period:

(A) 411-325-0025(3), (4), (5), (6), and (7);

(B) 411-325-0120(2), and (4);

(C) 411-325-0130;

(D) 411-325-0140;

(E) 411-325-0150;

(F) 411-325-0170;

(G) 411-325-0190;

(H) 411-325-0200;

(I) 411-325-0220(1), and (3);

(J) 411-325-0230;

(K) 411-325-0240, 0250, 0260, 0270, 0280, and 0290;

(L) 411-325-0300, 0340, and 0350;

(M) 411-325-0360; and

(N) 411-325-0380.

(b) Civil penalties of up to $300 per day per violation may be imposed for violations of any section of these rules not listed in subsection (a)(A) to (a)(N) of this section if a violation has been cited on two consecutive inspections or surveys of a 24-hour residential setting where such surveys are conducted by an employee of the Department. Penalties assessed under this section of this rule may not exceed $6,000 within a 90-day period.

(3) Monitoring occurs when a 24-hour residential setting is surveyed, inspected, or investigated by an employee or designee of the Department or an employee or designee of the Office of State Fire Marshal.

(4) In imposing a civil penalty pursuant to the schedule published in section (2) of this rule, the Department considers the following factors:

(a) The past history of the provider incurring a penalty in taking all feasible steps or procedures necessary or appropriate to correct any violation;

(b) Any prior violations of statutes or rules pertaining to 24-hour residential settings;

(c) The economic and financial conditions of the provider incurring the penalty; and

(d) The immediacy and extent to which the violation threatens or threatened the health, safety, or well-being of individuals.

(5) Any civil penalty imposed under ORS 443.455 and 441.710 becomes due and payable when the provider incurring the penalty receives a notice in writing from the Director of the Department. The notice referred to in this section of this rule is sent by registered or certified mail and includes:

(a) A reference to the particular sections of the statute, rule, standard, or order involved;

(b) A short and plain statement of the matters asserted or charged;

(c) A statement of the amount of the penalty or penalties imposed; and

(d) A statement of the right of the services provider to request a hearing.

(6) The person representing the provider to whom the notice is addressed has 20 days from the date of mailing of the notice in which to make a written application for a hearing before the Department.

(7) All hearings are conducted pursuant to the applicable provisions of ORS chapter 183.

(8) If the provider notified fails to request a hearing within 20 days, an order may be entered by the Department assessing a civil penalty.

(9) If, after a hearing, the provider is found to be in violation of a license, rule, or order listed in ORS 441.710(1), an order may be entered by the Department assessing a civil penalty.

(10) A civil penalty imposed under ORS 443.455 or 441.710 may be remitted or reduced upon such terms and conditions as the Director of the Department considers proper and consistent with individual health and safety.

(11) If the order is not appealed, the amount of the penalty is payable within 10 days after the order is entered. If the order is appealed and is sustained, the amount of the penalty is payable within 10 days after the court decision. The order, if not appealed or sustained on appeal, constitutes a judgment and may be filed in accordance with the provisions of ORS 183.745. Execution may be issued upon the order in the same manner as execution upon a judgment of a court of record.

(12) A violation of any general order or Final Order pertaining to a 24-hour residential setting issued by the Department is subject to a civil penalty in the amount of not less than $5 and not more than $500 for each and every violation.

(13) Judicial review of civil penalties imposed under ORS 441.710 are provided under ORS 183.480, except that the court may, in its discretion, reduce the amount of the penalty.

(14) All penalties recovered under ORS 443.455 and 441.710 to 441.740 are paid into the State Treasury and credited to the General Fund.

Stat. Auth.: ORS 409.050, 443.450, 443.455
Stats. Implemented: ORS 443.400-455

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 19-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 1-2012, f. & cert. ef. 1-6-12; SPD 1-2012, f. & cert. ef. 1-6-12; SPD 58-2013, f. 12-27-13, cert. ef. 12-28-13; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 24-2016, f. & cert. ef. 6-29-16

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Rule Caption: ODDS: Agency Certification and Endorsement - Medicaid Provider Enrollment Requirements
Adm. Order No.: APD 25-2016
Filed with Sec. of State: 6-29-2016
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Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently to updating the rules in:

- OAR chapter 411, division 323 for agency certification and endorsement to provide developmental disabilities services in community-based settings; and

- OAR chapter 411, division 370 for Medicaid provider enrollment requirements.

The rules in OAR chapter 411, division 323 are being amended to:

- Make permanent temporary changes that became effective on January 1, 2016;

- Remove general definitions included in OAR 411-317-0000;

- Demonstrate the Department's commitment to the Employment First Policy by assuring that only agencies that have a current endorsement are able to deliver employment services under OAR chapter 411, division 345;

- Provide for a two year phase-in period for certification of agencies previously certified under OAR chapter 411, division 340;

- Require endorsement to the rules in OAR chapter 411, division 323 and corresponding program rules when an agency was previously able to deliver attendant care or employment services under a different endorsement or was certified under OAR chapter 411, division 340. This requirement will be phased in over a two year period;

- Change the certification and endorsement periods from five to two years;

- Adopt the standards for home and community-based (HCB) services and settings and person-centered service planning adopted by the Department in OAR chapter 411, division 004 on January 1, 2016;

- Incorporate a new requirement that agency certification and endorsement is contingent upon meeting the standards for HCB services and settings and person-centered service planning in OAR chapter 411, division 004;

- Include correct references to OAR chapter 411, division 318 for individual rights to ensure uniform standards related to individual rights across all types of entities involved in the delivery of developmental disabilities services;

- Establish an alternate fiscal auditing standard for agencies with less than $1,000,000 revenue per fiscal year;

- Include current Medicaid and Department standards for reimbursement for the delivery of developmental disabilities services; and

- Reflect current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

The rules in OAR chapter 411, division 370 are being amended to:

- Require agencies endorsed to operate a Community Living Support Program under OAR chapter 411, division 450 to acquire a Medicaid provider number and meet the associated provider enrollment requirements; and

- Reflect current Department terminology, identify that Support Services Brokerages authorize developmental disabilities services, and perform minor grammar, punctuation, formatting, and housekeeping changes.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-323-0010
Statement of Purpose

(1) The rules in OAR chapter 411, division 323 prescribe standards, responsibilities, and procedures for agencies to obtain a certificate and endorsement in order to operate a program that delivers person-centered services to individuals with intellectual or developmental disabilities in a community-based setting as described in:

(a) OAR chapter 411, division 325 for 24-hour residential programs;

(b) OAR chapter 411, division 328 for supported living programs;

(c) OAR chapter 411, division 345 for employment supports; and

(d) OAR chapter 411, division 450 for community living supports.

(2) To operate a program described in section (1) of this rule that delivers person-centered services to individuals with intellectual or developmental disabilities, agencies must have:

(a) A certificate to provide Medicaid services in the state of Oregon as described in OAR 411-323-0030;

(b) Endorsement for each developmental disabilities program type as described in OAR 411-323-0035;

(c) A Medicaid Agency Identification Number assigned by the Department as described in OAR chapter 411, division 370; and

(d) For each licensed site or geographic location where direct services are to be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.

(e) Section (2) of this rule does not apply to an agency delivering community living supports that was certified, or that has applied for certification, according to OAR 411-340-0170 prior to January 1, 2016, until that organization requires renewal of its certification according to OAR 411-340-0030.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050
Hist.: SPD 12-2011, 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; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 35-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 25-2016, f. & cert. ef. 6-29-16

411-323-0020
Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 323:

(1) "Applicant" means a person, agency, corporation, or governmental unit who applies for certification and endorsement to operate an agency delivering services to individuals with intellectual or developmental disabilities.

(2) "Audit" means an inspection completed by a Certified Public Accountant using standards and accepted practices of accounting activities to ensure all state and federal funds are expended for the purpose the funds were contracted and intended for without fraudulent activity.

(3) "Audit Review" means a Certified Public Accountant, without applying comprehensive audit procedures, assesses the standards and accepted practices of accounting activities and ensures the accounting activities are in conformity with generally accepted accounting principles.

(4) "Board of Directors" means the group of people formed to set policy and give directions to an agency designed to provide services to individuals with intellectual or developmental disabilities. A board of directors may include local advisory boards used by multi-state organizations.

(5) "Certificate" means the document issued by the Department to an agency that certifies the agency is eligible to receive state funds for the delivery of services in an endorsed program.

(6) "Denial" means the refusal of the Department to issue:

(a) A certificate to operate an agency because the Department has determined the agency is not in compliance with these rules or the corresponding program rules; or

(b) An endorsement for an agency to operate a program because the Department has determined the agency is not in compliance with these rules or the corresponding program rules.

(7) "Endorsement" means the authorization to operate a program that delivers services. An endorsement is issued by the Department to a certified agency that has met the qualification criteria outlined in these rules and the corresponding program rules.

(8) "Executive Director" means the person designated by a board of directors or corporate owner of an agency that is responsible for the administration of the services delivered by the agency.

(9) "Informal Conference" means the discussion between the Department and an applicant or an agency that is held prior to a hearing to address any matters pertaining to the hearing. An administrative law judge does not participate in an informal conference. The informal conference may result in resolution of the issue.

(10) "ISP" means "Individual Support Plan".

(11) "Ownership Interest" means, as defined in 42 CFR 455.101, the possession of equity in the capital, the stock, or the profits of the disclosing entity as determined by 42 CFR 455.102. A person with an ownership or control interest means a person or corporation that:

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

(12) "Program Rules" mean the rules in:

(a) OAR chapter 411, division 325 for 24-hour residential programs;

(b) OAR chapter 411, division 328 for supported living programs;

(c) OAR chapter 411, division 345 for employment supports; and

(d) OAR chapter 411, division 450 for community living supports.

(13) "Program" means the services delivered by a provider agency as described in:

(a) OAR chapter 411, division 325 for 24-hour residential programs;

(b) OAR chapter 411, division 328 for supported living programs;

(c) OAR chapter 411, division 345 for employment programs; and

(d) OAR chapter 411, division 450 for community living programs.

(14) "Revocation" means the action taken by the Department to rescind:

(a) A certificate to operate an agency after the Department has determined that the agency is not in compliance with these rules or the corresponding program rules; or

(b) An endorsement for an agency to operate a program after the Department has determined that the agency is not in compliance with these rules or the corresponding program rules.

(15) "Suspension" means an immediate temporary withdrawal of the:

(a) Certificate to operate an agency after the Department determines that the agency is not in compliance with these rules or the corresponding program rules; or

(b) Endorsement for an agency to operate a program after the Department determines that the agency is not in compliance with these rules or the corresponding program rules.

(16) "These Rules" mean the rules in OAR chapter 411, division 323.

(17) "Variance" means a temporary exception from a regulation or provision of these rules that may be granted by the Department upon written application by the agency.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 409.050

Hist.: SPD 12-2011, 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; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 35-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 25-2016, f. & cert. ef. 6-29-16

411-323-0030
Certification

(1) CERTIFICATION. Except for an agency with a current certification, or that has applied for certification, according to OAR 411- 340-0140 prior to January 1, 2016, a person, agency, or governmental unit acting individually or jointly with any other person, agency, or governmental unit intending to operate a program as defined in OAR 411-323-0020 must be certified by the Department under these rules before establishing, conducting, maintaining, managing, or operating an agency.

(a) Certificates are not transferable.

(b) The Department issues or renews a certificate to an agency found to be in compliance with these rules, the rules in OAR chapter 411, division 004, and the corresponding program rules. The certificate is effective for two years from the date issued unless sooner revoked or suspended.

(c) If an agency fails to provide complete, accurate, and truthful information during the application or renewal process, the Department may delay initial certification, deny the application, or revoke or refuse to renew the application for certification.

(d) For the purpose of certification, any applicant or person with an ownership interest in an agency is considered responsible for acts occurring during, and relating to, the operation of the agency.

(e) The Department may consider the background and operating history of the applicant and each person with an ownership interest when determining whether to issue or renew a certificate.

(f) A review of the agency is conducted by the Department prior to the issuance or renewal of a certificate.

(2) CURRENT AGENCY CERTIFICATION.

(a) Within two years of January 1, 2016, all agency certification must be renewed as described in section (4) of this rule.

(b) All agencies, as of July 1, 2016, are certified for two years unless the certificate is sooner revoked or suspended.

(c) Agencies licensed or certified under OAR chapter 411, division 054 for residential care and assisted living facilities, OAR chapter 309, division 035 for residential treatment facilities for people who are mentally or emotionally disturbed, OAR chapter 413, division 215 for child welfare private child caring agencies, or OAR chapter 416, division 550 for youth offender treatment foster care, and as may be described in corresponding program rules, do not require additional certification as an agency under these rules to deliver services. Current license or certification is considered sufficient demonstration of ability to:

(A) Recruit, hire, supervise, and train qualified staff;

(B) Deliver services according to an ISP or Service Agreement; and

(C) Develop and implement operating policies and procedures required for managing an agency and delivering services, including provisions for safeguarding individuals receiving services.

(3) INITIAL CERTIFICATION. Notwithstanding section (2) of this rule, an applicant intending to provide program services as defined in OAR 411-323-0020 must apply for an initial certificate and demonstrate to the satisfaction of the Department that the applicant is in compliance with these rules, the rules in OAR chapter 411, division 004, and the corresponding program rules.

(a) The applicant must submit an application to the Department at least 90 days prior to the proposed date of delivery of services to individuals. The completed application must be on a form provided by the Department and must include all information requested by the Department.

(b) At a minimum, the applicant must provide:

(A) A copy of any management agreements or contracts relative to the operation and ownership of the agency;

(B) A financial plan that includes financial statements indicating capital and the financial plan developed to assure sustainability, partnerships, loans, and any other financial assistance; and

(C) As required by 42 CFR 455.104, the name, date of birth, and social security number for each person currently serving as the Board of Directors for the agency, and as changes are made.

(c) The applicant must develop a plan identifying the scope of services the applicant intends to provide and request endorsement for each program type as described in OAR 411-323-0035.

(d) The applicant must demonstrate proof of liability and operational insurance coverage.

(A) The agency must, at the expense of the agency, maintain in effect with respect to all occurrences taking place during the certification period, liability and operational insurance as described in the contract the agency has with the Department including, but not limited to, automobile liability insurance, comprehensive or commercial general liability insurance, and workers' compensation coverage if required.

(B) The agency must name the State of Oregon, Department of Human Services and the divisions, officers, and employees of the Department as additionally insured on any insurance policies required by their contract with respect to agency activities being performed under the certification of the agency. Such insurance must be issued by an insurance company licensed to do business in the state of Oregon and must contain a 30 day notice of cancellation endorsement.

(C) The agency must forward certificates of insurance indicating coverage to the Department as required by this rule.

(D) In the event of unilateral cancellation or restriction by the insurance company of any insurance coverage required by their contract, the agency must immediately notify the Department orally of the cancellation or restriction and must confirm the cancellation or restriction in writing within three days of receiving notification from the insurance company.

(4) CERTIFICATE RENEWAL.

(a) To renew a certificate, the agency must:

(A) Submit an application to the Department at least 90 days prior to the expiration date of the existing certificate for the agency. The completed application must be on a form provided by the Department and must include all information requested by the Department. At a minimum, the agency must provide:

(i) A copy of any management agreements or contracts relative to the operation and ownership of the agency;

(ii) A financial plan that includes audits for the last two years as described in section (5) of this rule; and

(iii) As required by 42 CFR 455.104, the name, date of birth, and social security number for each person currently serving as the Board of Directors for the agency, and as changes are made.

(B) Identify the scope of services the agency provides and provide proof of endorsement for each program service as described in OAR 411-323-0035;

(C) Demonstrate to the satisfaction of the Department that the agency is in compliance with these rules, the rules in OAR chapter 411, division 004, and the corresponding program rules; and

(D) Demonstrate proof of continued liability and operational insurance coverage as described in section (3)(d) of this rule.

(b) An application for renewal filed with the Department before the date of expiration extends the effective date of the existing certificate until the Department takes action upon the application for renewal.

(c) If the renewal application is not submitted to the Department prior to the date the certificate expires, the agency is considered a non-certified Medicaid agency and is subject to termination of their Medicaid Agency Identification Number.

(5) FINANCIAL AUDITS. Agencies certified and endorsed to provide program services, receiving revenue of $1,000,000 or more per fiscal year, must obtain an audit at least once during the biennium. Agencies certified and endorsed receiving less than $1,000,000 in revenue per fiscal year must submit an audit review as defined in OAR 411-323-0020 or another financial audit. The audit or the audit review must be submitted to the Department within 90 days of the end of the fiscal year.

(6) CERTIFICATE EXPIRATION. Unless revoked, suspended, or terminated earlier, each certificate to operate as a Medicaid provider agency expires two years following the date of issuance or December 31, 2017 if issued prior to January 1, 2016.

(7) CERTIFICATE TERMINATION. The certificate automatically terminates on the date agency operation is discontinued or if there is a change in ownership.

(8) RETURN OF CERTIFICATE. The certificate must be returned to the Department immediately upon suspension or revocation of the certificate or when agency operation is discontinued.

(9) CHANGE OF OWNERSHIP, LEGAL ENTITY, LEGAL STATUS, OR MANAGEMENT CORPORATION.

(a) The agency must notify the Department in writing of any pending change in the ownership, legal entity, legal status, or management corporation of the agency.

(b) A new certificate is required upon a change in the ownership, legal entity, legal status, or management corporation of the agency. The agency must submit an application as described in section (3) of this rule to the Department at least 30 days prior to a change in ownership, legal entity, legal status, or management corporation.

(10) CERTIFICATE ADMINISTRATIVE SANCTION. An administrative sanction may be imposed for non-compliance with these rules, the rules in OAR chapter 411 division 004, or the corresponding program rules. An administrative sanction on a certificate includes one or more of the following actions:

(a) A condition as described in section (11) of this rule;

(b) Denial, revocation, or refusal to renew a certificate as described in section (12) of this rule; or

(c) Immediate suspension of a certificate as described in section (13) of this rule.

(11) CERTIFICATE CONDITIONS.

(a) The Department may attach conditions to a certificate that limit, restrict, or specify other criteria for operation of the agency. The type of condition attached to a certificate must directly relate to the risk of harm or potential risk of harm to individuals.

(b) The Department may attach a condition to a certificate upon a finding that:

(A) Information on the application or initial inspection requires a condition to protect the health, safety, or welfare of individuals;

(B) A threat to the health, safety, or welfare of an individual exists;

(C) There is reliable evidence of abuse, neglect, or exploitation; or

(D) The agency is not being operated in compliance with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules.

(c) Conditions that the Department may impose on a certificate include, but are not limited to:

(A) Restricting the total number of individuals to whom an agency may provide services;

(B) Restricting the total number of individuals to whom an agency may provide services based upon the capability and capacity of the agency and staff to meet the health and safety needs of all individuals;

(C) Restricting the type of support and services the agency may provide to individuals based upon the capability and capacity of the agency and staff to meet the health and safety needs of all individuals;

(D) Requiring additional staff or staff qualifications;

(E) Requiring additional training;

(F) Restricting the agency from allowing a person on the premises who may be a threat to the health, safety, or welfare of an individual;

(G) Requiring additional documentation; or

(H) Restricting admissions.

(d) NOTICE OF CERTIFICATE CONDITIONS. The Department issues a written notice to the agency when the Department imposes conditions on the certificate of the agency. The written notice of certificate conditions includes the conditions imposed by the Department, the reason for the conditions, and the opportunity to request a hearing under ORS chapter 183. Conditions take effect immediately upon issuance of the written notice of certificate conditions or at a later date as indicated on the notice and are a Final Order of the Department unless later rescinded through the hearing process. The conditions imposed remain in effect until the Department has sufficient cause to believe the situation that warranted the condition has been remedied.

(e) HEARING. The agency may request a hearing in accordance with ORS chapter 183 and this rule upon receipt of written notice of certificate conditions. The request for a hearing must be in writing.

(A) The agency must request a hearing within 21 days from the receipt of the written notice of certificate conditions.

(B) In addition to, or in-lieu of a hearing, an agency may request an administrative review as described in section (14) of this rule. The request for an administrative review must be in writing. The administrative review does not diminish the right of the agency to a hearing.

(f) The agency may send a written request to the Department to remove a condition if the agency believes the situation that warranted the condition has been remedied.

(g) Conditions must be posted with the certificate in a prominent location and be available for inspection at all times.

(12) CERTIFICATE DENIAL, REFUSAL TO RENEW, OR REVOCATION.

(a) The Department may deny, refuse to renew, or revoke a certificate when the Department finds the agency or any person holding 5 percent or greater ownership interest in the agency:

(A) Demonstrates substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized and the agency fails to correct the non-compliance within 30 days from the receipt of written notice of non-compliance;

(B) Has demonstrated a substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized;

(C) Has been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of program services;

(D) Has been convicted of a misdemeanor associated with the operation of an agency or program services;

(E) Falsifies information required by the Department to be maintained or submitted regarding program services, agency finances, or funds belonging to the individuals;

(F) Has been found to have permitted, aided, or abetted any illegal act that has had significant adverse impact on individual health, safety, or welfare; or

(G) Has been placed on the current Centers for Medicare and Medicaid Services list of excluded or debarred providers maintained by the Office of the Inspector General.

(b) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may issue a notice of denial, refusal to renew, or revocation of a certificate following a Department finding that there is a substantial failure to comply with these rules, the rules in

OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in subsection (a) of this section has occurred.

(c) HEARING. An applicant for a certificate or a certified agency, as applicable, may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential setting, upon written notice from the Department of denial, refusal to renew, or revocation of a certificate. The request for a hearing must be in writing.

(A) DENIAL. The applicant must request a hearing within 60 days from the receipt of the written notice of denial.

(B) REFUSAL TO RENEW. The agency must request a hearing within 60 days from the receipt of the written notice of refusal to renew.

(C) REVOCATION.

(i) Notwithstanding subsection (ii) of this section, the agency must request a hearing within 21 days from the receipt of the written notice of revocation.

(I) In addition to, or in-lieu of a hearing, the agency may request an administrative review as described in section (14) of this rule. The request for an administrative review must be in writing.

(II) The administrative review does not diminish the right of the agency to a hearing.

(ii) An agency endorsed to operate a 24-hour residential program as described in OAR chapter 411, division 325 must request a hearing within 10 days from the receipt of the written notice of revocation.

(13) IMMEDIATE SUSPENSION OF CERTIFICATE.

(a) When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the agency, immediately suspend a certificate without a pre-suspension hearing and the agency may not continue operating.

(b) HEARING. The agency may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential setting, upon written notice from the Department of the immediate suspension of the certificate. The request for a hearing must be in writing.

(A) Notwithstanding subsection (B) of this section, the agency must request a hearing within 21 days from the receipt of the written notice of suspension.

(i) In addition to, or in-lieu of a hearing, the agency may request an administrative review as described in section (14) of this rule. The request for an administrative review must be in writing.

(ii) The administrative review does not diminish the right of the agency to a hearing.

(B) An agency endorsed to operate a 24-hour residential program as described in OAR chapter 411, division 325 must request a hearing within 10 days from the receipt of the written notice of suspension.

(14) ADMINISTRATIVE REVIEW.

(a) Notwithstanding subsection (b) of this section, the agency, in addition to the right to a hearing, may request an administrative review. The request for an administrative review must be in writing.

(b) An agency endorsed to operate a 24-hour residential program as described in OAR chapter 411, division 325 may not request an administrative review for revocation or suspension. An agency endorsed to operate a 24-hour residential program as described in OAR chapter 411, division 325 may request an administrative review for imposition of conditions.

(c) The Department must receive a written request for an administrative review within 10 business days from the receipt of the notice of suspension, revocation, or imposition of conditions. The agency may submit, along with the written request for an administrative review, any additional written materials the agency wishes to have considered during the administrative review.

(d) The determination of the administrative review is issued in writing within 10 business days from the receipt of the written request for an administrative review, or by a later date as agreed to by the agency.

(e) The agency, notwithstanding subsection (b) of this section, may request a hearing if the decision of the Department is to affirm the suspension, revocation, or condition. The request for a hearing must be in writing. The Department must receive the written request for a hearing within 21 days from the receipt of the original written notice of suspension, revocation, or imposition of conditions.

(15) INFORMAL CONFERENCE. Unless an administrative review has been completed as described in section (14) of this rule, an applicant or agency requesting a hearing may have an informal conference with the Department.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 409.050
Hist.: SPD 12-2011, 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; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 35-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 25-2016, f. & cert. ef. 6-29-16

411-323-0035
Endorsement

(1) ENDORSEMENT REQUIRED. Except for an agency with a current certification, or that has applied for certification, according to OAR 411-340-0140 prior to January 1, 2016, a person, agency, or governmental unit acting individually or jointly with any other person, agency, or governmental unit intending to operate a program type as defined in OAR 411-323-0020 must be endorsed by the Department under these rules before establishing, conducting, maintaining, managing, or operating a program.

(a) Except as described in OAR 411-450-0070, endorsements are not transferable or applicable to any other program type. Separate endorsements are required for each program type operated by a certified agency. A certified agency intending to operate additional program types once initial endorsement has been issued must apply for an additional endorsement as described in section (3) of this rule.

(b) If required by the program rules, each geographic location where a program operates must be reported by the agency to the Department and to the corresponding CDDP of the geographic location as described in this rule.

(c) The Department issues or renews an endorsement to a certified agency found to be in compliance with these rules, the rules in OAR chapter 411 division 004, and the corresponding program rules. The effective date for each endorsement corresponds with the effective date for the certification of the agency unless sooner revoked or suspended.

(d) If a certified agency fails to provide complete, accurate, and truthful information during the application or renewal process, the Department may delay initial endorsement, deny the application, or revoke or refuse to renew the endorsement of the program.

(e) For the purpose of endorsement, any applicant or person with an ownership interest in a certified agency is considered responsible for acts occurring during, and relating to, the operation of the agency.

(f) The Department may consider the background and operating history of the applicant and each person with an ownership interest when determining whether to issue or renew an endorsement.

(g) A review of the certified agency is conducted by the Department prior to the issuance or renewal of an endorsement.

(2) CURRENT AGENCY ENDORSEMENT.

(a) All certified agencies endorsed to operate a program as of January 1, 2016 are endorsed for not more than two years.

(b) A certified agency intending to operate additional program types must apply for endorsement as described in section (3) of this rule.

(c) Agencies licensed or certified under OAR chapter 411, division 054 for residential care and assisted living facilities, OAR chapter 309, division 035 for residential care treatment facilities for individuals who are mentally or emotionally disturbed, OAR chapter 413, division 215 for child welfare private child caring agencies, or OAR chapter 416, division 550 for youth offender treatment foster care, and as may be described in corresponding program rules, do not require additional endorsement as an agency under these rules to deliver services described in the program rules.

(3) INITIAL ENDORSEMENT.

(a) Notwithstanding section (2) of this rule, a certified agency intending to operate a program as defined in OAR 411-323-0020 must apply for initial endorsement and demonstrate to the satisfaction of the Department that the agency is in compliance with these rules, the rules in OAR chapter 411 division 004, and the corresponding program rules.

(b) The certified agency must submit an application to the Department at least 90 days prior to delivering services that identifies the program type that the certified agency intends to operate.

(A) All geographic locations where programs are to be operated must be identified on the application, if required by the program rules.

(B) The completed application must be on a form provided by the Department and must include all information requested by the Department.

(C) Each licensed site or geographic location where direct services are to be delivered must be assigned a Medicaid Performing Provider Number by the Department as described in OAR chapter 411, division 370.

(4) ENDORSEMENT RENEWAL.

(a) To renew endorsement, the certified agency must:

(A) Submit an application to the Department at least 90 days prior to the expiration date of the existing endorsement for the certified agency. The completed application must identify the program type that the certified agency provides and all geographic locations where program services are

provided, when required by the program rules. The completed application must be on a form provided by the Department and must include all information requested by the Department.

(B) Demonstrate to the satisfaction of the Department that the certified agency is in compliance with these rules, the rules in OAR chapter 411 division 004, and the corresponding program rules.

(b) Only existing program types are endorsed on renewal. A certified agency requesting to operate additional program types must apply for initial endorsement as described in section (3) of this rule.

(c) An application for renewal filed with the Department before the date of expiration extends the effective date of the existing endorsement until the Department takes action upon the application for renewal.

(d) A certified agency may not operate a program if a renewal application is not submitted to the Department prior to the date the endorsement expires.

(e) Renewal of endorsements for a program is contingent upon the successful renewal of the certificate of the agency.

(5) EXISTING ENDORSEMENT — ADDING A GEOGRAPHIC LOCATION. Adding a geographic location to an existing endorsement must be reported by the agency to the Department and to the corresponding CDDP of the geographic location. The agency must report the additional geographical location on a form provided by the Department at least 30 days prior to delivering services at the additional geographic location.

(6) ENDORSEMENT EXPIRATION. Unless revoked, suspended, or terminated earlier, the effective date of each endorsement corresponds with the effective date of the certification of the agency.

(7) ENDORSEMENT TERMINATION. Endorsement automatically terminates on the date programs are discontinued or agency certification is terminated.

(8) CHANGE OF CERTIFICATION. New endorsement is required upon a change of the certification of an agency. The recertified agency must submit an application for endorsement as described in section (3) of this rule to the Department at least 30 days prior to a change of the certification of the agency including, but not limited to, a change in ownership, legal entity, legal status, or management corporation.

(9) ENDORSEMENT ADMINISTRATIVE SANCTION. An administrative sanction may be imposed for non-compliance with these rules, the corresponding program rules, or the rules in OAR chapter 411 division 004. An administrative sanction on an endorsement includes one or more of the following actions:

(a) A condition as described in section (10) of this rule:

(b) Denial, revocation, or refusal to renew an endorsement as described in section (11) of this rule; or

(c) Immediate suspension of an endorsement as described in section (12) of this rule.

(10) ENDORSEMENT CONDITIONS.

(a) The Department may attach conditions to an endorsement that limit, restrict, or specify other criteria for a program. The type of condition attached to an endorsement must directly relate to a risk of harm or potential risk of harm to individuals.

(b) The Department may attach a condition to an endorsement upon a finding that:

(A) Information on the application or initial inspection requires a condition to protect the health, safety, or welfare of individuals;

(B) A threat to the health, safety, or welfare of an individual exists;

(C) There is reliable evidence of abuse, neglect, or exploitation; or

(D) The agency is not being operated in compliance with these rules, the rules in OAR chapter 411 division 004, or the corresponding program rules.

(c) Conditions that the Department may impose on an endorsement include, but are not limited to:

(A) Restricting the total number of individuals to whom an agency may deliver services;

(B) Restricting the total number of individuals to whom an agency may deliver services based upon the capability and capacity of the agency and staff to meet the health and safety needs of all individuals;

(C) Restricting the type of support and services the agency may deliver to individuals based upon the capability and capacity of the agency and staff to meet the health and safety needs of all individuals;

(D) Requiring additional staff or staff qualifications;

(E) Requiring additional training;

(F) Restricting the agency from allowing a person on the premises who may be a threat to the health, safety, or welfare of an individual;

(G) Requiring additional documentation; or

(H) Restricting admissions.

(d) NOTICE OF ENDORSEMENT CONDITIONS. The Department issues a written notice to the agency when the Department imposes conditions on the endorsement of a program The written notice of endorsement conditions includes the conditions imposed by the Department, the reason for the conditions, and the opportunity to request a hearing under ORS chapter 183. Conditions take effect immediately upon issuance of the written notice of conditions or at a later date as indicated on the notice and are a Final Order of the Department unless later rescinded through the hearing process. The conditions imposed remain in effect until the Department has sufficient cause to believe the situation that warranted the condition has been remedied.

(e) HEARING. The agency may request a hearing in accordance with ORS chapter 183 and this rule upon written notice of endorsement conditions. The request for a hearing must be in writing.

(A) The agency must request a hearing within 21 days from the receipt of the written notice of conditions.

(B) In addition to, or in lieu of a hearing, the agency may request an administrative review as described in section (13) of this rule. The request for an administrative review must be in writing. The administrative review does not diminish the right of the agency to a hearing.

(f) The agency may send a written request to the Department to remove a condition if the agency believes the situation that warranted the condition has been remedied.

(g) Conditions must be posted with the endorsement in a prominent location and be available for inspection at all times.

(11) ENDORSEMENT DENIAL, REFUSAL TO RENEW, OR REVOCATION.

(a) The Department may deny, refuse to renew, or revoke an endorsement when the Department finds the agency or any person holding 5 percent or greater ownership interest in the agency:

(A) Fails to maintain agency certification as described in OAR 411-323-0030;

(B) Demonstrates substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized and the agency fails to correct the non-compliance within 30 days from the receipt of the written notice of non-compliance;

(C) Has demonstrated a substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized;

(D) Has been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of services;

(E) Has been convicted of a misdemeanor associated with the operation of an agency or program services;

(F) Falsifies information required by the Department to be maintained or submitted regarding program services, agency finances, or funds belonging to the individuals;

(G) Has been found to have permitted, aided, or abetted any illegal act that has had significant adverse impact on individual health, safety, or welfare; or

(H) Has been placed on the list of excluded or debarred providers maintained by the Office of the Inspector General.

(b) NOTICE OF ENDORSEMENT DENIAL, REFUSAL TO RENEW, OR REVOCATION. The Department may issue a notice of denial, refusal to renew, or revocation of an endorsement following a Department finding that there is a substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in subsection (a) of this section has occurred.

(c) HEARING. An applicant for an endorsement or an endorsed agency, as applicable, may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential setting, upon written notice from the Department of denial, refusal to renew, or revocation of an endorsement. The request for a hearing must be in writing.

(A) DENIAL. The applicant must request a hearing within 60 days from the receipt of the written notice of denial.

(B) REFUSAL TO RENEW. The agency must request a hearing within 60 days from the receipt of the written notice of refusal to renew.

(C) REVOCATION.

(i) Notwithstanding subsection (ii) of this section, the agency must request a hearing within 21 days from the receipt of the written notice of revocation.

(I) In addition to, or in lieu of a hearing, an agency may request an administrative review as described in section (13) of this rule. The request for an administrative review must be in writing.

(II) The administrative review does not diminish the right of the agency to a hearing.

(ii) An agency endorsed to operate a 24-hour residential program as described in OAR chapter 411, division 325 must request a hearing within 10 days from the receipt of the written notice of revocation.

(12) IMMEDIATE SUSPENSION OF ENDORSEMENT.

(a) When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the agency, immediately suspend an endorsement without a pre-suspension hearing and the program may not continue operating.

(b) HEARING. The agency may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential program, upon written notice from the Department of the immediate suspension of the endorsement. The request for a hearing must be in writing.

(A) Notwithstanding subsection (B) of this section, the endorsed agency must request a hearing within 21 days from the receipt of the written notice of suspension.

(i) In addition to, or in-lieu of a hearing, the agency may request an administrative review as described in section (13) of this rule. The request for an administrative review must be in writing.

(ii) The administrative review does not diminish the right of the agency to a hearing.

(B) An agency endorsed to operate a 24-hour residential program as described in OAR chapter 411, division 325 must request a hearing within 10 days from the receipt of the written notice of suspension.

(13) ADMINISTRATIVE REVIEW.

(a) Notwithstanding subsection (b) of this section, the agency, in addition to the right to a hearing, may request an administrative review. The request for an administrative review must be in writing.

(b) An agency endorsed to operate a 24-hour residential program as described in OAR chapter 411, division 325 may not request an administrative review for revocation or suspension. An agency endorsed to operate a 24-hour residential program as described in OAR chapter 411, division 325 may request an administrative review for imposition of conditions.

(c) The Department must receive a written request for an administrative review within 10 business days from the receipt of the notice of suspension, revocation, or imposition of conditions. The agency may submit, along with the written request for an administrative review, any additional written materials the agency wishes to have considered during the administrative review.

(d) The determination of the administrative review is issued in writing within 10 business days from the receipt of the written request for an administrative review, or by a later date as agreed to by the agency.

(e) The agency, notwithstanding subsection (b) of this section, may request a hearing if the decision of the Department is to affirm the suspension, revocation, or condition. The request for a hearing must be in writing. The Department must receive the written request for a hearing within 21 days from the receipt of the original written notice of suspension, revocation, or imposition of conditions.

(14) INFORMAL CONFERENCE. Unless an administrative review has been completed as described in subsection (13) of this rule, an applicant or agency requesting a hearing may have an informal conference with the Department.

Stat. Auth. ORS 409.050

Stats. Implemented: ORS 409.050

Hist.: SPD 19-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 1-2012, f. & cert. ef. 1-6-12; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 35-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 25-2016, f. & cert. ef. 6-29-16

411-323-0050

Agency Management and Personnel Practices

(1) NON-DISCRIMINATION. The agency must comply with all applicable state and federal statutes, rules, and regulations in regard to non-discrimination in employment policies and practices.

(2) BASIC PERSONNEL POLICIES AND PROCEDURES. The agency must have in place and implement personnel policies and procedures that address suspension, increased supervision, or other appropriate disciplinary employment procedures when a staff member, provider, or subcontractor, including relief providers and volunteers, has been identified as an accused person in an abuse investigation or when an allegation of abuse has been substantiated.

(3) PROHIBITION AGAINST RETALIATION. The agency or provider may not retaliate against any staff member or subcontractor including relief providers and volunteers that report in good faith suspected abuse or retaliate against the individual with respect to any report. An accused person may not self-report solely for the purpose of claiming retaliation.

(a) Any agency, provider, or person that retaliates against any person because of a report of suspected abuse or neglect is liable according to ORS 430.755 in a private action to the reporting person for actual damages and, in addition, is subject to a penalty up to $1000, notwithstanding any other remedy provided by law.

(b) Any adverse action is evidence of retaliation if taken within 90 days of a report of abuse. For purposes of this section, "adverse action" means any action taken by an agency, provider, or person involved in a report against the person making the report or against the individual because of the report and includes, but is not limited to:

(A) Discharge or transfer from the agency, except for clinical reasons;

(B) Discharge from or termination of employment;

(C) Demotion or reduction in remuneration for program services; or

(D) Restriction or prohibition of access to the agency or the individuals receiving services by the agency.

(4) MANDATORY ABUSE REPORTING PERSONNEL POLICIES AND PROCEDURES.

(a) Any staff, providers, substitute caregivers, independent contractors of the agency, and volunteers are mandatory reporters.

(b) The agency must notify all staff, providers, substitute caregivers, independent contractors of the agency, and volunteers of mandatory reporting status at least annually on forms provided by the Department.

(c) The agency must provide all staff, providers, substitute caregivers, independent contractors of the agency, and volunteers with a Department produced card regarding abuse reporting status and abuse reporting requirements.

(d) Agencies providing services to adults must report suspected abuse to the CDDP where the adult resides. A report must also be made to law enforcement if there is reason to believe a crime has been committed.

(e) Agencies providing services to children must report suspected abuse to the Department or law enforcement in the county where the child resides.

(5) APPLICATION FOR EMPLOYMENT. An application for employment at the agency must inquire whether an applicant has had any founded reports of child abuse or substantiated adult abuse.

(6) BACKGROUND CHECKS. Any staff, volunteer, provider, relief care provider, crisis provider, advisor, 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 an agency, who has or shall have contact with an individual in services, must have an approved background check in accordance with OAR 407-007-0200 to 407-007-0370 and ORS 181.534.

(a) The agency may not use public funds to support, in whole or in part, any person described above in section (6) of this rule in any capacity who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(b) Subsection (a) of this section does not apply to agency staff who were hired prior to July 28, 2009 that remain in the current position for which the staff member was hired.

(c) Any person described above in section (6) of this rule must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and 407-007-0290. The person must notify the Department or the designee of the Department within 24 hours.

(7) EXECUTIVE DIRECTOR QUALIFICATIONS. The agency must be operated under the supervision of an Executive Director who has a minimum of a bachelor's degree and two years of experience, including supervision, in intellectual or developmental disabilities, mental health, rehabilitation, social services, or a related field. Six years of experience in the identified fields may be substituted for a degree.

(8) GENERAL STAFF QUALIFICATIONS. Any staff member providing services to individuals must meet the following criteria:

(a) Be at least 18 years of age;

(b) Consent to and pass a background check by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (6) of this rule, and be free of convictions or founded allegations of abuse by the appropriate agency including, but not limited to, the Department;

(A) Background rechecks must be performed biennially, or as needed, if a report of criminal activity has been received by the Department.

(B) PORTABILITY OF BACKGROUND CHECK APPROVAL. A subject individual as defined in OAR 407-007-0210 may be approved for one position to work in multiple locations within the qualified entity as defined in OAR 407-007-0210. The Background Check Request form must be completed by the subject individual to show intent to work at various locations.

(c) If hired on or after 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) Hold a current, valid, and unrestricted professional license or certification where services and supervision requires specific professional education, training, and skill;

(f) Understand requirements of maintaining confidentiality and safeguarding individual information;

(g) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General;

(h) Be literate and capable of understanding written and oral orders;

(i) Be able to communicate with individuals, health care providers, case managers, and appropriate others;

(j) Be able to respond to emergency situations at all times that services are being delivered;

(k) Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;

(l) Receive 12 hours of job-related in-service training annually;

(m) Have clear job responsibilities as described in a current signed and dated job description;

(n) If transporting individuals, have a valid license to drive and vehicle insurance in compliance with the laws of the Department of Motor Vehicles; and

(o) Additional qualifications may exist in the applicable program rules for the staff of an agency endorsed to those rules.

(9) PERSONNEL FILES AND QUALIFICATION RECORDS. The agency must maintain up-to-date written job descriptions for all staff as well as a file available to the Department or the designee of the Department for inspection that includes written documentation of the following for each staff member:

(a) Written documentation that references and qualifications were checked;

(b) Written documentation by the Department of an approved background check as defined in OAR 407-007-0210;

(c) Written documentation of staff notification of mandatory abuse training and reporter status prior to supervising individuals and annually thereafter;

(d) Written documentation of any complaints filed against the staff member and the results of the complaint process, including, if any, disciplinary action;

(e) Written documentation of any founded report of child abuse or substantiated adult abuse;

(f) Written documentation of 12 hours of job-related in-service training annually;

(g) Documentation that the staff member has been certified in CPR and First Aid by a recognized training agency within 90 days of employment and that certification is kept current; and

(h) For staff operating vehicles that transport individuals, documentation of a valid license to drive and proof of vehicle insurance in compliance with the laws of the Department of Motor Vehicles.

(10) DISSOLUTION OF AN AGENCY. A representative of the governing body or owner of an agency must notify the Department in writing 30 days prior to the dissolution of the agency and make appropriate arrangements for the transfer of individual records.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050
Hist.: SPD 12-2011, 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; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 25-2016, f. & cert. ef. 6-29-16

411-323-0060
Policies and Procedures

(1) HEALTH. The agency must have and implement policies and procedures that maintain and protect the health of individuals.

(2) INDIVIDUAL AND FAMILY INVOLVEMENT. The agency must have and implement a written policy that addresses:

(a) Opportunities for the individual to participate in decisions regarding the operations of the agency;

(b) Opportunities for families, guardians, legal and designated representatives, and significant others of the individuals to interact; and

(c) Opportunities for individuals, families, guardians, legal and designated representatives, and significant others to participate on the Board of Directors or on committees or to review policies of the agency that directly affect the individuals receiving services from the agency.

(3) CONFIDENTIALITY OF RECORDS. The agency must have and implement written policies and procedures that ensure all records for individuals are kept confidential except as otherwise provided by applicable state and federal rule or laws.

(a) For the purpose of disclosure from individual medical records under this rule, an agency is considered a "public provider" as defined in ORS 179.505.

(b) Access to records by the Department does not require authorization by an individual or the legal or designated representative or family of the individual.

(c) For the purpose of disclosure of non-medical individual records, all or portions of the information contained in the non-medical individual records may be exempt from public inspection under the personal privacy information exemption to the public records law set forth in ORS 192.502.

(4) BEHAVIOR SUPPORT. The agency must have and implement a written policy for behavior support that utilizes individualized positive behavioral theory and practice and prohibits abusive practices.

(5) PROTECTIVE PHYSICAL INTERVENTION. The agency must have and implement written policies and procedures for protective physical interventions that address the following:

(a) The agency must only employ protective physical intervention techniques that are included in the approved OIS curriculum or as approved by the OIS Steering Committee.

(b) Protective physical intervention techniques must only be applied:

(A) When the health and safety of an individual or others is at risk, the ISP team has authorized the procedures as documented by the decision of the ISP team, the procedures are documented in the ISP, and the procedures are intended to lead to less restrictive intervention strategies;

(B) As an emergency measure if absolutely necessary to protect the individual or others from immediate injury; or

(C) As a health-related protection prescribed by a physician, if absolutely necessary during the conduct of a specific medical or surgical procedure, or for the protection of an individual during the time that a medical condition exists.

(6) HANDLING AND MANAGING INDIVIDUALS' MONEY. The agency must have and implement written policies and procedures for the handling and management of money for the individuals. Such policies and procedures must provide for:

(a) Financial planning and management of the funds for an individual;

(b) Safeguarding the funds for an individual;

(c) Individuals receiving and spending their own money; and

(d) Taking into account the interests and preferences of the individual.

(7) COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015.

(b) The agency must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015.

(c) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(8) AGENCY DOCUMENTATION REQUIREMENTS. The agency must have and implement policies and procedures that address agency documentation requirements. Documentation must:

(a) Be prepared at the time or immediately following the event being recorded;

(b) Be accurate and contain no willful falsifications;

(c) Be legible, dated, and signed by the person making the entry; and

(d) Be maintained for no less than three years.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 409.050
Hist.: SPD 12-2011, 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; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 35-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 25-2016, f. & cert. ef. 6-29-16

411-323-0065
Payment to Agency Providers

(1) Authorization for payment in the appropriate electronic payment system must occur prior to the delivery of services

(2) Payment is made after services are delivered.

(3) For a service to be eligible for payment it must be included on a written agreement that specifies, at a minimum, the type and amount of

services to be delivered. The written agreement must be signed by the provider and may be:

(a) The individual ISP; or

(b) A service agreement specific to the individual.

(4) A provider must request payment authorization from the case management entity for services provided during an unforeseeable emergency on the first business day following the emergency service. A case manager must determine if the service is eligible for payment.

(5) Travel time of the provider to reach the setting where services are delivered, when not directly providing services to the individual, is not reimbursable.

(6) Payment by the Department for a service is considered full payment for the services rendered under Medicaid. A provider may not demand or receive additional payment for services rendered under Medicaid from the individual, parent, guardian, or any other source, under any circumstances.

(7) Medicaid funds are the payer of last resort. A provider must bill all third party resources until all third party resources are exhausted.

(8) The Department reserves the right to make a claim against any third party payer before or after making payment to the provider.

(9) Upon submission of a request for payment, a provider must comply with:

(a) All applicable rules in OAR chapter 407 and OAR chapter 411;

(b) 45 CFR Part 84 which implements Title V, Section 504 of the Rehabilitation Act of 1973 as amended;

(c) Title II and Title III of the Americans with Disabilities Act of 1991; and

(d) Title VI of the Civil Rights Act of 1964.

(10) All billings must be for services provided within the licensure and certification of the provider.

(11) The provider must submit true and accurate information with request for payment.

(12) An agency may not submit the following to the Department:

(a) A false request for payment;

(b) A request for payment that has been, or is expected to be, paid by another source; or

(c) Any request for payment for services that have not been provided.

(13) The Department only makes payment to an enrolled provider who actually performs the services or the enrolled provider organization. Federal regulations prohibit the Department from making payment to a collection agency.

(14) Payment is denied if any provisions of these rules, the rules in OAR chapter 411, division 004, or the associated program rules are not complied with.

(15) The Department may recoup overpayments as described in OAR 407-120.

(16) In order to be eligible for payment, requests for payments must be submitted to the Department within 12 months of the delivery of services.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007, 430.215
Hist.: APD 25-2016, f. & cert. ef. 6-29-16

411-323-0070
Variances

(1) The Department may grant a variance to these rules or the corresponding program rules based upon a demonstration by an agency that an alternative method or different approach provides equal or greater agency effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws.

(2) The agency requesting a variance must submit a written application to the Department that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept, or procedure proposed; and

(d) If the variance applies to the services for an individual, evidence that the variance is consistent with the currently authorized ISP for the individual.

(3) The request for a variance is approved or denied by the Department. The decision of the Department is sent to the agency, the CDDP, and to all relevant Department programs or offices within 30 days from the receipt of the variance request.

(4) The agency may request an administrative review of the denial of a variance request. The Department must receive a written request for an administrative review within 10 business days from the receipt of the denial. The decision of the Director is the final response from the Department.

(5) The duration of the variance is determined by the Department.

(6) The agency may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 409.050
Hist.: SPD 12-2011, 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; APD 24-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 42-2014, f. 12-26-14, cert. ef. 12-28-14; APD 25-2016, f. & cert. ef. 6-29-16

411-370-0010
Definitions

(1) "Administrator" means the administrators of the Department of Human Services or that person's designee.

(2) "Appropriate Service" means services that are required by a recipient's approved individual service or support plan that are:

(a) Consistent with the recipient's identified needs, goals, and desired outcomes;

(b) Appropriate with regard to standards of generally recognized practice, evidence based practice, and professional standards of service as effective;

(c) Not solely for the convenience of a provider of the service;

(d) The most cost effective of the alternative services that may be effectively provided to a recipient; and

(e) Coordinated with the recipient's local case management entity.

(3) "Authorization" means either service or payment authorization for specified covered services given prior to services being rendered by Department staff, or the Department's designee including community developmental disability programs and support services brokerages.

(4) "Billing Provider" means an individual, agent, business, corporation, or other entity who, in connection with submission of claims to the Department, receives or directs payment from the Department on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider.

(5) "Claim" means a bill for services, a line item of a service, or all services for one recipient within a specified billing period. Claims include a bill submission, an invoice, or an encounter associated with requesting payment whether submitted on paper or electronically. Claim also includes any other methodology for requesting payment or as verification of an expenditure of an advanced payment that may be established in contract, provider enrollment agreement, or program-specific rules.

(6) "Express Payment and Reporting System (eXPRS)" means the Department's information system that tracks and documents service delivery of claims funded by the Department.

(7) "Community Developmental Disability Program (CDDP)" as defined in OAR 411-320-0020.

(8) "Community Services Programs" are developmental disability services provided for recipients under the following program names, service element numbers, or descriptions:

(a) Nursing facility specialized services (DD45) as described in OAR chapter 411, division 070.

(b) Residential programs (DD50) as described in OAR chapter 411, division 325.

(c) Supported living programs (DD51) as described in OAR chapter 411, division 328.

(d) Transportation services (DD 53) as described in the applicable service element standards and procedures and Community Transportation services described in OAR 411-435.

(e) Employment programs as described in OAR chapter 411, division 345.

(f) Community Living Supports as described in OAR chapter 411, division 450.

(g) Rent subsidies (DD 56) as described in the applicable service element standards and procedures.

(h) Developmental disabilities special projects (DD 57) as described in the applicable service element standards and procedures.

(i) Children's residential programs (DD142) as described in OAR chapter 411, division 325.

(j) Room and board (DD 156) as described in the applicable service element standards and procedures.

(9) "Covered Services" mean appropriate services that are funded by the legislature and applicable Department rules describing the community services programs provided to eligible recipients under service element standards and procedures, program-specific requirements, provider enrollment agreements, or contracts by providers required to enroll with the Department under these rules.

(10) "Date of Service" means the date the recipient receives community services program services, unless otherwise specified in the appropriate program-specific rules.

(11) "Department" means the Department of Human Services. For the purpose of these rules, Department also includes the responsibility for the day-to-day operation and administration of 1915(c) Home and Community-Based Services waiver and the 1915(k) Community First Choice State Plan Option programs of DHS as the operating agency designated by OHA.

(12) "Express Payment and Reporting System (eXPRS)" means the Department's information system for managing the disbursement and tracking of Department funding for certain developmental disability programs.

(13) "False Claim" means a claim or encounter that a provider knowingly submits or causes to be submitted that contains inaccurate or misleading information, and that information would result, or has resulted, in an overpayment or other improper payment.

(14) "Fraud" means an intentional deception or misrepresentation made by a recipient or provider with the knowledge that the deception may result in some unauthorized benefit to himself or herself, or some other recipient or provider. Fraud includes any act that constitutes fraud or false claim under applicable federal or state law.

(15) "Medicaid" means a federal and state funded program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by the Department.

(16) "Medicaid Agency Identification Number" means the numeric identifier assigned by the Department to an enrolled provider once enrollment of that provider is completed as described in these rules.

(17) "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 these rules. The Medicaid Performing Provider Number is used by the rendering provider for identification and billing purposes associated with service authorizations and payments.

(18) "Medicaid Fraud Control Unit (MFCU)" means the unit of the Oregon Department of Justice that investigates and prosecutes billing fraud committed by Medicaid providers. MFCU also may investigate and prosecute physical, sexual, or financial abuse and neglect of residents who reside in Medicaid-funded facilities.

(19) "Medicaid Management Information System (MMIS)" means the automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of MMIS include verifying provider enrollment and client eligibility, managing health care provider claims and benefit package maintenance, and addressing a variety of Medicaid business needs.

(20) "Medicare" means the federal health insurance program for the aged and disabled administered by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act.

(21) "OHA" means Oregon Health Authority. OHA is the Single State Medicaid Agency for Oregon and retains ultimate authority and responsibility for the administration of the Medicaid State Plan.

(22) "Provider" or "Performing Provider" means an individual, agency, corporate entity, or other organization that provides community services program services that is enrolled with the Department in accordance with these rules to seek payment from the Department.

(23) "Quality Improvement" means the effort to improve the level of performance of key processes, practices, or outcomes in service provision. A quality improvement program measures the level of current performance of the processes and practices, finds ways to improve the performance or outcomes, and implements new and better methods for the processes or practices. Quality improvement includes the goals of quality assurance, quality control, quality planning, and quality management.

(24) "Recipient" means an individual found eligible by the community developmental disability program and the Department to receive community services program services for individuals with developmental disabilities under OAR chapter 411, division 320.

(25) "Service Element Standards and Procedures" means the standard for a particular service element number that further describes the applicable service and details the purpose, performance requirements, special reporting requirements, and applicable rules to adhere to when providing that particular service element.

(26) "SFMA" means the Oregon Statewide Financial Management Services.

(27) "Suspension" means a sanction prohibiting a provider's participation in the Department's community services programs by deactivation of the assigned provider number for a specified period of time or until the occurrence of a specified event.

(28) "These Rules" mean the rules in OAR chapter 411, division 370.

(29) "Third Party Resource (TPR)" means a service or financial resource that, by law, is available and applicable to pay for covered services for community services programs.

(30) "United States Department of Health & Human Services (USDHHS)" means the Cabinet department of the United States government with the goal of protecting the health of all Americans and providing essential human services.

Stat. Auth.: ORS 409.050, 410.070, 411.060 & 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610 to 430.695 & 443.400 to 443.455
Hist.: SPD 16-2011, f. & cert. ef. 7-1-11; APD 35-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 25-2016, f. & cert. ef. 6-29-16

411-370-0020
Provider Requirements

(1) These rules cover all programs and services of the Department's community services programs for recipients with developmental disabilities (hereinafter referred to as community services programs). All providers seeking payment from the Department for the provision of covered services to eligible service recipients of community services programs must comply with these rules and the applicable rules, standards, and procedures of the specific programs or services defined as community services programs in OAR 411-370-0010.

(2) COVERED PROVIDER AGREEMENTS. Agreements with providers for community services programs may include:

(a) Direct contracts with the Department;

(b) Contracts with Department designees, including CDDPs; or

(c) Provider enrollment agreements with the Department.

(3) Covered services paid for with state, Medicaid (Title XIX), or other funds by the Department for community services programs are also subject to federal and state Medicaid rules and requirements. In interpreting these rules and program-specific rules, the Department shall construe them as much as possible in a manner that shall comply with federal and state laws and regulations, and the terms and conditions of federal waivers and the state plans.

(4) A provider paid with state or Medicaid funds for community services programs must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid services under the Medicaid Act, Title XIX, 42 United States Code (USC) 1396 et seq.

(5) Payment for any service by a provider of community services programs may not be made by or through (directly or by power of attorney) any individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the person or organization for an added fee or a deduction of a portion of the accounts receivable.

(6) The Department shall make community services programs provider payments to only the following:

(a) The provider who actually performed the service;

(b) In accordance with a reassignment from the provider to a government agency or reassignment by a court order; or

(c) To an enrolled billing provider, such as a billing service or an accounting firm that, in connection with the submission of claims, receives or directs payments in the name of the provider, if the billing provider's compensation for this service is:

(A) Related to the cost of processing the billing; and

(B) Not related on percentage or other basis to the amount that is billed or collected and not dependent upon the collection of the payment.

(7) Providers must comply with TPR requirements in Department policies, program-specific rules, provider enrollment agreements, or contracts.

(8) PROGRAM INTEGRITY.

(a) The Department shall use several approaches to promote integrity of the community services programs. This section of the rule describes integrity actions related to:

(A) Provider billings and payments, including actions and expectations contained within service element standards and procedures, program-specific rules, or contracts with Department representatives including CDDPs or brokerages. The program integrity goal is to pay the correct amount to a properly enrolled provider for covered services provided to an eligible recipient according to these rules and the program-specific services in effect on the date of the service; and

(B) Provider performance in the delivery of services to recipients as well as general program practices. The program integrity goal includes approaches to assure the provision of appropriate services for which payment is to be made as well as compliance with these rules, service element

standards and procedures, program-specific rules, provider enrollment agreements, or contracts.

(b) Program integrity activities include but are not limited to the following:

(A) Review, including but not limited to the evaluation of services in accordance with appropriate service or process, error identification, and prior authorization processes including all actions taken to determine the provision of services in accordance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contract;

(B) Onsite visits to verify compliance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts;

(C) Quality improvement activities;

(D) Coordination with the Department of Justice MFCU and other oversight authorities including law enforcement; and

(E) For provider billings and payments:

(i) Implementation of transaction standards to improve accuracy and timeliness of claims processing;

(ii) Cost report settlement processes;

(iii) Audits; and

(iv) Investigation of false claims, fraud, or prohibited business relationships.

(F) For provider service delivery:

(i) Provider licensing or certification required responsibilities and activities; and

(ii) Specific service monitoring and evaluation activities provided in program-specific rules or Department policy.

(c) The following may engage in program integrity activities including but not limited to general monitoring of the provider's performance in service delivery, reviewing a request for services, or auditing a claim of services, before or after payment, for assurance that the specific care or service was provided in accordance with the program-specific rules and the generally accepted standards of performance:

(A) Department staff or designees, including staff of a CDDP or brokerage; and

(B) Federal or state oversight authority.

(d) Payment may be denied or may be subject to recovery if the review or audit determines the service was not provided in accordance with provider rules, program-specific rules, provider enrollment agreements or contracts, or does not meet the criteria for quality or appropriateness of the service or payment.

(e) If the Department or other federal or state oversight authorities determine that an overpayment has been made to a provider, the amount of overpayment is subject to recovery.

(f) The provider may face other sanctions or penalties, including termination of provider enrollment agreements or contracts as allowed by program-specific or Department rules.

(g) The Department may communicate with and coordinate any program integrity actions with the MFCU, USDHHS, other federal or state oversight authorities including law enforcement, or Department designees including CDDPs and brokerages.

Stat. Auth.: ORS 409.050, 410.070, 411.060 & 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610 to 430.695 & 443.400 to 443.455

Hist.: SPD 16-2011, f. & cert. ef. 7-1-11; APD 25-2016, f. & cert. ef. 6-29-16

411-370-0030

Provider Enrollment

(1) For the purpose of this rule, all providers of community services programs, authorized to utilize the eXPRS, SFMA, or MMIS, and licensed or certified by Department rules, or otherwise qualified by program-specific rules, prior to July 1, 2011 shall be deemed to be an enrolled provider as of July 1, 2011, subject to all provisions of these rules.

(2) Being an enrolled provider is a condition of eligibility for a Department payment for claims in community services programs. The Department requires billing providers to be enrolled as providers consistent with the provider enrollment processes set forth in this rule. If payment for community services program services shall be made under a contract with the Department or the Department's designees, including CDDPs, the provider must also meet the contract requirements. Contract requirements are separate from the requirements of these provider enrollment rules.

(3) Enrollment as a provider with the Department is not a promise that the enrolled provider shall receive any minimum amount of work from the Department, or the Department's designees, including CDDPs.

(4) RELATION TO SERVICE ELEMENT STANDARDS AND PROCEDURES, PROGRAM-SPECIFIC RULES, PROVIDER ENROLLMENT AGREEMENT, OR CONTRACT REQUIREMENTS. Provider enrollment establishes essential provider participation requirements for becoming an enrolled provider for the Department. The details of provider qualification requirements, recipient eligibility, covered services, how to obtain service authorization, documentation requirements, claims submission, available electronic access instructions, and other pertinent instructions and requirements are contained in the service element standards and procedures, program-specific rules, or provider enrollment agreement or contract.

(5) CRITERIA FOR ENROLLMENT. To be enrolled providers must:

(a) Meet the requirements, if applicable, of the statewide agency certification process as prescribed in OAR chapter 411, division 323.

(b) Meet all program-specific requirements identified in service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts in addition to the requirements identified in these rules;

(c) Meet Department licensing, certification, or service endorsement requirements for the type of community services programs the provider shall deliver as described in the program-specific rules, provider enrollment agreements, or contracts; and

(d) Obtain a Medicaid Agency Identification Number and applicable Medicaid Performing Provider Number from the Department for the specific services for which the provider is enrolling.

(6) PARTICIPATION AS AN ENROLLED PROVIDER. Participation with the Department as an enrolled provider is open to qualified providers that:

(a) Meet the qualification requirements established in these rules and program-specific rules, provider enrollment agreements, or contracts;

(b) Enroll as a provider with the Department in accordance with these rules;

(c) Provide or shall provide a covered service within their scope of licensure, certification, or service endorsement, if applicable, to an eligible recipient in accordance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts; and

(d) Accept the payment amounts established in accordance with the Department's program-specific payment structures, service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts for services providers.

(7) ENROLLMENT PROCESS. To be enrolled as a provider with the Department, an individual or organization must submit a complete and accurate provider enrollment form, provider disclosure form, and provider enrollment agreement, available from the Department.

(a) PROVIDER ENROLLMENT REQUEST FORM. The provider enrollment form requests basic demographic information about the provider that shall be permanently associated with the provider or organization until changed on an updated form. For the purpose of provider enrollment, the Department may use, instead of the provider enrollment form required under these rules, the application for certification required under OAR chapter 411, division 323 if such an application is applicable to the provider.

(b) PROVIDER DISCLOSURE FORM. All individuals and entities are required to disclose information used by the Department to determine whether an exclusion applies that would prevent the Department from enrolling the provider. Individual performing providers must submit a disclosure statement. All providers that are enrolling as an entity (corporation, non-profit, partnership, sole proprietorship, governmental) must submit a disclosure of ownership and control interest statement. For the purpose of provider enrollment, the Department may use, instead of the provider disclosure form required under these rules, the application for certification required under OAR chapter 411, division 323 if such an application is applicable to the provider.

(A) Entities must disclose all the information required on the disclosure of ownership and control interest statement.

(B) Payment may not be made to any individual or entity that has been excluded from participation in federal or state programs or that employs or is managed by excluded individuals or entities.

(C) The Department may refuse to enter into or may suspend or terminate a provider enrollment agreement if the individual performing provider or any individual who has an ownership or control interest in the entity, or who is an agent or managing employee of the provider, has been sanctioned or convicted of a criminal offense related to that individual's involvement in any program established under Medicare, Medicaid, Title XIX services, or other public assistance program.

(D) The Department may refuse to enter into or may suspend or terminate a provider enrollment agreement or contract for provider services, if the Department determines that the provider did not fully and accurately make any disclosure required under this rule.

(8) PROVIDER ENROLLMENT AGREEMENT. The provider must sign the provider enrollment agreement and submit it to the Department for review at the time the provider submits the provider enrollment form and related documentation. Signing the provider enrollment agreement constitutes agreement by a provider to comply with all applicable Department service element standards and procedures, provider and program rules, and applicable federal and state laws and regulations in effect on the date of service. The provider enrollment agreement must be submitted even if alternatives to submitting the provider enrollment form and provider disclosure form are used, as provided in sections (7)(a) and (7)(b) of this rule.

(9) ENROLLMENT OF PROVIDERS. A provider shall be enrolled, assigned, and issued a Medicaid Agency Identification Number and Medicaid Performing Provider Number upon the following criteria:

(a) Provider submission, consistent with Department procedures, of a completed and signed provider enrollment form, provider disclosure form, provider enrollment agreement, any applicable provider licensure, certification, or service endorsement materials, and all other required documents to the Department.

(b) Provider signature on required forms must be the provider or an individual with actual authority for the provider to legally bind the provider to attest and certify to the accuracy and completeness of the information submitted.

(c) The provisions of this rule, OAR chapter 411, division 323 if applicable, program-specific rules, service element standards and procedures, provider enrollment agreements, or contracts relating to provider qualifications, certification, licensure, and service endorsement are completed.

(10) Provider enrollment is not complete until all required information has been submitted, verified, and the Medicaid Agency Identification Number and the Medicaid Performing Provider Number are issued.

(11) CLAIM OR ENCOUNTER SUBMISSION. Submission of a claim or encounter or other payment request document constitutes the enrolled provider's agreement that:

(a) The service was provided in compliance with all applicable rules and requirements in effect on the date of service;

(b) The provider has created and maintained all records necessary to disclose the extent of services provided and provider's compliance with applicable program and financial requirements, and that the provider agrees to make such information available upon request to the Department or the Department's designees including CDDPs, brokerages, the MFCU (for Medicaid-funded services), the Oregon Secretary of State, and (for federally-funded services) the federal funding authority and the Comptroller General of the United States;

(c) The information on the claim or encounter, regardless of the format or other payment document, is true, accurate, and complete; and

(d) The provider understands that payment of the claim or encounter or other payment document shall be from federal or state funds, or a combination of federal and state funds, and that any falsification, or concealment of a material fact, may result in prosecution under federal and state laws.

(12) Medicaid Agency Identification Numbers and Medicaid Performing Provider Numbers shall be specific to the provider, and the service sites, locations, or type of service authorized by the Department or the Department's designee including CDDPs and support services brokerages. Issuance of a Department-assigned Medicaid Agency Identification Number and Medicaid Performing Provider Number establishes enrollment of an individual or organization as a provider for community services programs.

(13) Providers must provide the following updates:

(a) An enrolled provider must notify the Department in writing of a material change in any status or condition on any element of their provider enrollment form. Providers must notify the Department of the following changes in writing within 30 calendar days:

(A) Business affiliation;

(B) Ownership;

(C) Federal tax identification number;

(D) Ownership and control information; or

(E) Criminal convictions.

(b) Claims submitted by, or payments made to, providers who have not timely furnished the notification of changes or have not submitted any of the items that are required due to a change may be denied payment or payment may be subject to recovery.

(14) The provider enrollment agreement may be terminated as follows:

(a) PROVIDER TERMINATION REQUEST.

(A) The provider may ask the Department to terminate the provider enrollment agreement upon the following conditions and timelines unless otherwise required by service element standards and procedures, program-specific rules, or provider enrollment agreement or contract.

(i) Upon the provider's convenience with at least 90 days advance written notice; or

(ii) Upon a minimum of 30 days advance written notice if the Department does not meet the obligations under these rules and such dispute remains unresolved at the end of the 30 day period or such longer period, if any, as specified by the provider in the notice.

(B) The request must be in writing, signed by the provider, and mailed or delivered to the Department. The notice must specify the Department-assigned Medicaid Agency Identification Number and Medicaid Performing Provider Number, if known.

(C) When accepted, the Department shall assign the Medicaid Agency Identification Number and Medicaid Performing Provider Number a termination status and the effective date of the termination status.

(D) Termination of the provider enrollment agreement does not relieve the provider of any obligations for covered services provided under these rules in effect for dates of services during which the provider enrollment agreement was in effect.

(b) DEPARTMENT TERMINATION. Pursuant to the provisions of OAR chapter 407, division 120, the Department may terminate the provider enrollment agreement immediately upon notice to the provider, or a later date as the Department may establish in the notice, upon the occurrence of any of the following events:

(A) The Department fails to receive funding, appropriations, limitations, or other expenditure authority at levels that the Department or the specific program determines to be sufficient to pay for the services covered under the agreement;

(B) Federal or state laws, regulations, or guidelines are modified or interpreted by the Department in a such a way that either providing the services under the agreement is prohibited or the Department is prohibited from paying for such services from the planned funding source;

(C) The Department has issued a final order revoking the Department-assigned Medicaid Agency Identification Number, service endorsement, or Medicaid Performing Provider Number based on a sanction; or

(D) The provider no longer holds a required license, certificate, service endorsement, or other authority to qualify as a provider. The termination shall be effective on the date the license, certificate, service endorsement, or other authority is no longer valid.

(c) In the event of any termination of the provider enrollment agreement, the provider's sole monetary remedy is limited to covered services the Department determines to be compensable under the provider agreement, a claim for unpaid invoices, hours worked within any limits set forth in the agreement but not yet billed, and Department-authorized expenses incurred prior to termination. Providers are not entitled to recover indirect or consequential damages. Providers are not entitled to attorney fees, costs, or other expenses of any kind.

(15) IMMEDIATE SUSPESION. When a provider fails to meet one or more of the requirements governing participation as a Department enrolled provider, the provider's Department-assigned Medicaid Agency Identification Number or Medicaid Performing Provider Number may be immediately suspended consistent with the provisions of OAR chapter 407, division 120. The provider may not provide services to recipients during a period of suspension. The Department shall deny claims for payment or other payment requests for dates of service during a period of suspension.

(16) The provision of a program-specific provider enrollment agreement or contract covered services to eligible recipients is voluntary on the part of the provider. Providers are not required to serve all recipients seeking service.

(17) The provider performs all services as an independent contractor. The provider is not an officer, employee, or agent of the Department.

(18) The provider is responsible for its employees and for providing employment-related benefits and deductions that are required by law. The provider is solely responsible for its acts or omissions including the acts or omissions of its own officers, employees, or agents. The Department's responsibility shall be limited to the Department's authorization and payment obligations for covered services provided in accordance with these rules.

Stat. Auth.: ORS 409.050, 410.070, 411.060 & 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610 to 430.695 & 443.400 to 443.455
Hist.: SPD 16-2011, f. & cert. ef. 7-1-11; APD 25-2016, f. & cert. ef. 6-29-16

411-370-0040
Variances

(1) The Department may grant a variance to these rules based upon a demonstration by the provider that an alternative method or different approach provides equal or greater effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws.

(2) The provider requesting a variance must submit, in writing, an application on a Department approved form that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance; and

(c) The alternative practice, service, method, concept, or procedure proposed.

(3) The Department shall approve or deny the request for a variance. In reviewing the variance request, the Department may seek input or information from the Department's designees, including CDDPs and brokerages.

(4) The Department's decision shall be sent to the provider and to all relevant Department programs or offices within 30 calendar days of the receipt of the variance request.

(5) The provider may appeal the denial of a variance request by sending a written request for review to the Administrator, whose decision is final.

(6) The Department shall determine the duration of the variance.

(7) The provider may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 411.060, 410.070 & 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610-695 & 443.400–443.455
Hist.: SPD 16-2011, f. & cert. ef. 7-1-11; APD 25-2016, f. & cert. ef. 6-29-16

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Rule Caption: ODDS: General Definitions and Acronyms for Developmental Disabilities Services
Adm. Order No.: APD 26-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 5-1-2016
Rules Amended: 411-317-0000
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the general definitions and acronyms for developmental disabilities services in OAR 411-317-0000.

OAR 411-317-0000 is being updated to:

- Make permanent temporary changes that became effective January 1, 2016;
- Provide consistency and streamline definitions;
- Incorporate definitions for home and community-based (HCB) services and settings and person-centered service planning to implement the regulations and expectations of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS); and
- Reflect current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-317-0000
Definitions for Developmental Disability Services

This rule, OAR 411-317-0000, defines terms frequently used in OAR chapter 411, divisions 300 to 450 for developmental disabilities services. OAR chapter 411, divisions 300 to 450 may include definitions specific to the subject matter in that division. If a word or term is defined differently than what is in this rule, the definition in that division applies, when used in that division.

(1) "24-Hour Residential Program" means the distinct method for the delivery of person centered services as described in these rules by a certified and endorsed provider in one or more 24-hour residential settings.

(2) "24-Hour Residential Setting" means a residential home, apartment, or duplex licensed by the Department under ORS 443.410 in which home and community-based services are provided to individuals with intellectual or developmental disabilities. A 24-hour residential setting is considered a provider owned, controlled, or operated residential setting.

(3) "Abuse" means:

(a) For a child:

(A) "Abuse" as defined in ORS 419B.005; and

(B) "Abuse" as defined in OAR 407-045-0260 when a child resides in a 24-hour residential setting licensed by the Department as described in OAR chapter 411, division 325.

(b) For an individual between the ages of 18 and 21 residing in a certified child foster home, "abuse" as defined in OAR 407-045-0260.

(c) For an adult, "abuse" as defined in OAR 407-045-0260.

(4) "Abuse Investigation" means the 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.

(5) "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.

(6) "Activities of Daily Living (ADL)" are the basic personal everyday activities, such as eating, using the restroom, grooming, dressing, bathing, and transferring. ADL services include, but are not limited to:

(a) Basic personal hygiene - providing or assisting with needs, such as bathing (tub, bed, bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene;

(b) Toileting, bowel, and bladder care - assisting to and from the bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, managing menses, cleansing an individual or adjusting clothing related to toileting, emptying a catheter, drainage bag, or assistive device, ostomy care, or bowel care;

(c) Mobility, transfers, and repositioning - assisting with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(d) Nutrition — assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with adaptive utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(e) Delegated nursing tasks;

(f) First aid and handling emergencies - addressing medical incidents related to the conditions of an individual, such as seizure, aspiration, constipation, or dehydration, responding to the call of the individual for help during an emergent situation, or for unscheduled needs requiring immediate response;

(g) Assistance with necessary medical appointments - help scheduling appointments, arranging medical transportation services, accompaniment to appointments, follow up from appointments, or assistance with mobility, transfers, or cognition in getting to and from appointments; and

(h) Observation of the status of an individual and reporting of significant changes to a physician, health care provider, or other appropriate person.

(7) "Administration of Medication" means the act of placing a medication in or on the body of an individual by a person responsible for the care of the individual and employed by, or under contract to, the individual or as applicable the legal or designated representative of the individual or provider organization.

(8) "Administrator Review" means the Director of the Department reviews a decision upon request, including the documentation related to the decision, and issues a determination.

(9) "Adult" means an individual who is 18 years of age or older with an intellectual or developmental disability.

(10) "Advocate" means a person other than paid staff who has been selected by an individual or by the legal representative of an individual 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.

(11) "Agency" means a public or private community agency or organization that is certified by the Department to deliver developmental disabilities services.

(12) "Aids to Physical Functioning" means any special equipment prescribed for an individual by a physician, therapist, or dietician that maintains or enhances the physical functioning of the individual.

(13) "Alternative Resources" mean possible resources, not including developmental disabilities services, for the provision of supports to meet the needs of an individual. Alternative resources include, but are not limited to, private or public insurance, vocational rehabilitation services, supports available through the Oregon Department of Education, or other community supports.

(14) "Annual Plan" means the written summary a services coordinator or personal agent completes for an individual who is not enrolled in waiver or Community First Choice state plan services. An Annual Plan is not an ISP and is not a plan of care for Medicaid purposes.

(15) "Attendant Care" means an hourly service that provides assistance with ADL, IADL, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding. It is available through the Community First Choice State Plan Amendment.

(16) "Authority" means "Oregon Health Authority".

(17) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210.

(18) "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. The baseline level of behavior serves as the reference point by which the ongoing efficacy of a BSP is to be assessed.

(19) "Bedroom" means the personal space and sleeping area of an individual receiving home and community-based services in a provider owned, controlled, or operated residential setting, as agreed to in the Residency Agreement.

(20) "Behavior Consultant" means a contractor with specialized skills who meets the minimum qualifications defined in the Community First Choice state plan who conducts functional assessments and develops a Behavior Support Plan.

(21) "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.

(22) "Behavior Data Summary" means the document composed to summarize episodes of protective physical intervention. The behavior data summary serves as a substitution for the requirement of an incident report for each episode of protective physical intervention.

(23) "Behavior Support Plan" means the written strategy, based on person-centered planning and a functional assessment that outlines specific instructions for a primary caregiver or provider to follow in order to reduce the frequency and intensity of the challenging behaviors of an individual and to and to modify the behavior of the primary caregiver or provider, adjust environment, and teach new skills.

(24) "Behavior Support Services" mean the services consistent with positive behavioral theory and practice that are delivered in accordance with a Behavior Support Plan to assist with behavioral challenges due to the intellectual or developmental disability of an individual that prevents the individual from accomplishing ADL, IADL, health-related tasks, and provides cognitive supports to mitigate behavior.

(25) "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 services for individuals with intellectual or developmental disabilities.

(26) "BSP" means "Behavior Support Plan".

(27) "Career Development Plan":

(a) Means the part of an ISP that identifies:

(A) The employment goals and objectives for an individual;

(B) The services and supports needed to achieve those goals;

(C) The people, agencies, and providers assigned to assist the individual to attain those goals;

(D) The obstacles to the individual working in an individualized job in a competitive integrated employment setting; and

(E) The services and supports necessary to overcome those obstacles.

(b) A Career Development Plan is based on person-centered planning principles.

(28) "Case Management Contact" means a reciprocal interaction between a case manager and an individual or the legal or designated representative of the individual (as applicable).

(29) "Case Management Entity" means a CDDP, a Brokerage, a CIIS program, or the Department's Children's Residential Program.

(30) "Case Management Services" means the functions performed by a case manager that are funded by the Department. Case management services include, but are not limited to:

(a) Assessment of support needs;

(b) Developing an ISP or annual plan that may include authorized services;

(c) Information and referral for services; and

(d) Monitoring the effectiveness of services and supports.

(31) "Case Manager" means a person who delivers case management services who meets the qualifications of OAR 411-415-0040 and is employed:

(a) As a personal agent by a Brokerage;

(b) As a services coordinator by a CDDP; or

(c) As a services coordinator by the Department.

(32) "CDDP" means "Community Developmental Disabilities Program".

(33) "Centers for Medicare and Medicaid Services". The Centers for Medicare and Medicaid Services is the federal agency within the United States Department of Health and Human Services responsible for the administration of Medicaid and the Health Insurance Portability and Accountability Act (HIPAA) and overseeing Medicaid programs administered by the states through survey and certification.

(34) "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.

(35) "Child" means an individual under the age of 18.

(36) "Children's Intensive In-Home Services" includes case management from a Department employed services coordinator and the services authorized by the Department delivered through:

(a) The ICF/ID Behavioral Program;

(b) The Medically Fragile Children's Program; and

(c) The Medically Involved Children's Waiver.

(37) "Choice" means the expression of preference, opportunity for, and active role of an individual in decision-making related to services received and from whom including, but not limited to, case management, providers, services, and service settings. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated through a variety of methods, including orally, through sign language, or by other communication methods.

(38) "Choice Advising" means the impartial sharing of information to individuals with intellectual or developmental disabilities about:

(a) Case management options;

(b) Service options;

(c) Service setting options; and

(d) Provider types.

(39) "CIIS" means "Children's Intensive In-Home Services".

(40) "Claimant" means the person directly impacted by an action that is the subject of a hearing request.

(41) "CME" means "Case Management Entity".

(42) "CMS" means "Centers for Medicare and Medicaid Services".

(43) "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.

(44) "Community Developmental Disabilities Program" means the entity that is responsible for plan authorization, delivery, and monitoring of services for individuals who are not enrolled in a Brokerage. A Community Developmental Disabilities Program 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.

(45) "Community First Choice (K Plan)" means the state plan amendment for Oregon authorized under section 1915(k) of the Social Security Act.

(46) "Community Living Supports" means attendant care, skills training, and relief care, alone or in combination.

(47) "Community Transportation" means the ancillary service that provides for the services that enable an individual to gain access to community-based state plan and waiver services, activities and resources that are not medical in nature. Community transportation is provided in the area surrounding the home of the individual that is commonly used by people in the same area to obtain ordinary goods and services. Community transportation is available through the Community First Choice State Plan Amendment.

(48) "Complaint" means an oral or written expression of dissatisfaction with a developmental disabilities service or provider.

(49) "Complaint Investigation" means the investigation of a complaint that has been made to a proper authority that is not covered by an investigation of abuse.

(50) "Complaint Log" means a list of complaint-related information.

(51) "Completed Application" means an application required by the Department that:

(a) Is filled out completely, signed, and dated. An applicant who is unable to sign may sign with a mark, witnessed by another person; and

(b) Contains documentation required to make an eligibility determination as outlined in OAR 411-320-0080.

(52) "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 provider.

(53) "Continuing Services" means the continuation of a developmental disabilities service following the request for a hearing. Services continue until a Final Order is issued.

(54) "Cost Effective" means being responsible and accountable with Department resources by offering less costly alternatives when providing choices that adequately meet the support needs of an individual. Less costly alternatives include other service settings available from the Department and the utilization of assistive devices, natural supports, environmental modifications, and alternative resources. Less costly alternatives may include resources not paid for by the Department.

(55) "County of Origin" means:

(a) For an adult, the county of residence for the adult; and

(b) For a child, the county where the jurisdiction of guardianship exists.

(56) "Day" means a calendar day unless otherwise specified.

(57) "DD Administrative Hearing Request" means form APD 0443DD.

(58) "Denial" means any rejection of a request for a developmental disabilities service or an increase in a developmental disabilities service. A denial of a Medicaid service requires a Notification of Planned Action.

(59) "Delegation" is the process by which a registered nurse authorizes an unlicensed person to perform nursing tasks and confirms that authorization in writing. Delegation may occur only after a registered nurse follows all steps of the delegation process as outlined in OAR chapter 851, division 047.

(60) "Department" means "Department of Human Services".

(61) "Department Hearing Representative" means a person authorized by the Department to represent the Department in a hearing as described in OAR 411-001-0500.

(62) "Department Staff" means a person employed by the Department who is knowledgeable in a particular subject matter.

(63) "Designated Representative" means:

(a) A person who is 18 years of age or older, such as a parent, family member, guardian, or advocate, who is:

(A) Chosen by an individual or the legal representative of the individual;

(B) Not a paid provider for the individual; and

(C) Authorized by the individual or, as applicable, the legal representative of the individual to serve as the representative of the individual or, as applicable, the legal representative in connection with the provision of funded supports.

(b) The power to act as a designated representative is valid until an individual modifies the authorization.

(c) An individual or the legal representative of the individual is not required to appoint a designated representative.

(64) "Developmental Disability" means a neurological condition that:

(a) Originates before an individual is 22 years of age or 18 y-ears of age for an intellectual disability;

(b) Originates in and directly affects the brain and has continued, or is expected to continue, indefinitely;

(c) Constitutes significant impairment in adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080;

(d) Is not primarily attributed to other conditions including, but not limited to, a mental or emotional disorder, sensory impairment, motor impairment, substance abuse, personality disorder, learning disability, or Attention Deficit Hyperactivity Disorder (ADHD); and

(e) Requires training and support similar to an individual with an intellectual disability as described in OAR 411-320-0080.

(65) "Developmental Disabilities Services" mean services provided by or authorized by a CDDP, Brokerage, or ODDS that are comprised of:

(a) Case management services described in OAR chapter 411, division 415;

(b) Services available through the Community First Choices 1915(k) state plan amendment; and

(c) Services available through a 1915(c) waiver.

(66) "Director" means the Director of the Department of Human Services, Office of Developmental Disabilities Services or Office of Licensing and Regulatory Oversight, or the designee of the Director, which may include Department Staff.

(67) "Domestic Animals" means the animals domesticated so as to live and breed in a tame condition, such as dogs, cats, and domesticated farm stock.

(68) "Employer" means, for the purposes of obtaining services through a personal support worker, the common law employer. The common law employer is the individual or a person selected by the individual or the legal representative conduct the responsibilities of an employer. An employer may also be a designated representative.

(69) "Employer-Related Supports" mean the activities that assist an individual, and when applicable the legal or designated representative or family members of the individual, with directing and supervising provision of services described in the ISP for an individual. Employer-related supports may 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 service agreements; and

(d) Fiscal intermediary services.

(70) "Employment Service" means a home and community-based service that supports the primary objective of exploring, obtaining, maintaining, or advancing in an individual job in a competitive integrated employment setting in the general workforce.

(a) Employment services under the rules in OAR chapter 411, division 345 include:

(A) Supported Employment.

(i) Individual Employment Support.

(I) Job Coaching.

(II) Job Development.

(ii) Small Group Employment Support.

(B) Discovery.

(C) Employment Path Services.

(b) Employment services do not include vocational assessments in sheltered workshop settings or facility-based settings. Employment services do not include new participants in sheltered workshop settings.

(71) "Entity" means a person, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation of a state.

(72) "Entry" means the initial enrollment to a Department-funded developmental disabilities service delivered by a provider agency or case management entity.

(73) "Exit" means termination or discontinuance of a Department-funded developmental disabilities service.

(74) "Family Member" means spouse, 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.

(75) "Founded Report" means the determination by the Department or Law Enforcement Authority (LEA), 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.

(76) "Functional Needs Assessment" means the comprehensive assessment or reassessment appropriate to the specific program in which an individual is enrolled that:

(a) Documents physical, mental, and social functioning;

(b) Identifies risk factors and support needs; and

(c) Determines the service level.

(77) "General Business Provider" means an organization or entity selected by an individual or the legal representative of the individual and paid with Department funds that:

(a) Is primarily in business to provide the service chosen by the individual or the legal representative of 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 person who actually provides support for the individual.

(78) "Good Cause" means an excusable mistake, surprise, excusable neglect (which may include neglect due to a significant cognitive or health issue), circumstances beyond the control of a claimant, reasonable reliance on the statement of Department Staff or an adverse provider relating to pro-

cedural requirements, [or due to] fraud, misrepresentation, or other misconduct of the Department or a party adverse to a claimant.

(79) "Guardian" means the parent for an individual under the age of 18 or a person or agency appointed and authorized by a court to make decisions about services for an individual.

(80) "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. Examples of a health care provider include, but are not limited to, a registered nurse (RN), nurse practitioner (NP), licensed practical nurse (LPN), medical doctor (MD), osteopathic physician (DO), chiropractor, respiratory therapist (RT), physical therapist (PT), physician assistant (PA), dentist, or occupational therapist (OT).

(81) "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.

(82) "Hearing" means a contested case hearing subject to OAR 137-003-0501 to 137-003-0070, which results in a final order.

(83) "Home" means the primary residence for an individual that is not under contract with the Department to provide services certified as a foster home for children under OAR chapter 411, division 346 or licensed as a foster home for adults under OAR chapter 411, division 360 or a licensed or certified residential care facility, assisted living facility, nursing facility, or other residential setting.

(a) A home for a child may include a foster home funded by Child Welfare.

(b) A foster home funded by Child Welfare is considered a provider owned, controlled, or operated residential setting.

(84) "Home and Community-Based Services" are services provided in the home or community of an individual.

(a) Home and community-based services are authorized under the following Medicaid authorities:

(A) 1915(c) — HCBS Waivers;

(B) 1915(i) — State Plan HCBS; or

(C) 1915(k) — Community First Choice (K State Plan Option).

(b) Home and community-based services are delivered through the following program areas:

(A) Department of Human Services, Aging and People with Disabilities;

(B) Department of Human Services, Office of Developmental Disabilities Services; and

(C) Oregon Health Authority.

(c) Home and community-based services may include alternative resources specifically authorized as home and community-based by the Department or Authority.

(85) "Home and Community-Based Setting" means a physical location meeting the qualities of OAR 411-004-0020 where an individual receives home and community-based services.

(86) "Hospital Level of Care" means a child:

(a) Has a documented medical condition and demonstrates the need for active treatment as assessed by the clinical criteria; and

(b) The medical condition requires the care and treatment of services normally provided in an acute medical hospital.

(87) "IADL" means "Instrumental Activities of Daily Living".

(88) "ICF/ID" means "Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities".

(89) "ICF/IDD Level of Care" means an individual meets the following institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities:

(a) The individual has an intellectual disability or a developmental disability as defined in this rule and meets the eligibility criteria in OAR 411-320-0080 for developmental disabilities services; and

(b) The individual has a significant impairment in one or more areas of adaptive behavior as determined in OAR 411-320-0080.

(90) "IEP" means "Individualized Education Program".

(91) "Incident Report" means the written report of any injury, accident, act of physical aggression, use of protective physical intervention, or unusual incident involving an individual.

(92) "Independence" means the extent to which an individual exerts control and choice over his or her own life.

(93) "Independent Provider" means:

(a) A personal support worker; or

(b) An independent contractor delivering services including nursing services, discovery, job development, or behavior consultation.

(94) "Individual" means a child, young adult, or an adult applying for, or determined eligible for, Department-funded developmental disabilities services.

(95) "Individualized Education Program" is the written plan of instructional goals and objectives developed in conference with an individual, the parent or legal representative of an individual (as applicable), teacher, and a representative of the public school district.

(96) "Individually-Based Limitations" means any limitation to the qualities outlined in OAR 411-004-0020(2)(c) to (2)(j), due to health and safety risks. An individually-based limitation is based on specific assessed need and only implemented with the informed consent of the individual or, as applicable, the legal representative of the individual, as described in OAR 411-004-0040.

(97) "Individual Support Plan" includes the written details of the supports, activities, and resources required for an individual to achieve and maintain personal goals and health and safety. The ISP is developed at least annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The ISP reflects services and supports that are important to meet the needs of the individual identified through a functional needs assessment as well as the preferences for providers, delivery, and frequency of services and supports. The ISP is the plan of care for Medicaid purposes and reflects whether services are provided through a waiver, the Community First Choice state plan, natural supports, or alternative resources.

(98) "Instrumental Activities of Daily Living" are the activities other than activities of daily living required to continue independent living as described in the Community First Choice state plan amendment.

(99) "Intake" means the activity of completing the DD Intake Form (APD 0552) and necessary releases of information prior to the submission of a completed application to the CDDP.

(100) "Integrated Employment Setting" means employment at a location where an employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and that, as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions. Employment in an Integrated Employment Setting cannot be facility-based work in a Sheltered Workshop, and cannot be non-work activities such as day support activities.

(101) "Integration" as defined in ORS 427.005 means:

(a) Use by individuals receiving developmental disabilities services of the same community resources used by and available to other people;

(b) Participation by individuals receiving developmental disabilities services in the same community activities in which people without disabilities participate, together with regular contact with people without disabilities; and

(c) Residence by individuals receiving developmental disabilities services in homes or in home-like settings that are in proximity to community resources, together with regular contact with people without disabilities in their community.

(102) "Intellectual Disability" means significantly sub-average general intellectual functioning defined as full scale intelligence quotients (IQs) 70 and under as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior directly related to an intellectual disability as described in OAR 411-320-0080 that is manifested during the developmental period prior to 18 years of age. Individuals with a valid full scale IQ of 71-75 may be considered to have an intellectual disability if there is also significant impairment in adaptive behavior as diagnosed and measured by a licensed clinical or school psychologist as described in OAR 411-320-0080.

(103) "Involuntary Reduction" means a provider has made the decision to reduce services provided to an individual without prior approval from the individual.

(104) "Involuntary Transfer" means a provider has made the decision to transfer an individual without prior approval from the individual.

(105) "ISP" means "Individual Support Plan".

(106) "ISP Team" means a team composed of an individual receiving services, the legal or designated representative of the individual (as applicable), services coordinator or personal agent, and others chosen by the individual, or as applicable the legal representative of the individual, such as providers and family members.

(107) "Legal Representative" means a person who has the legal authority to act for an individual. The legal representative only has author-

ity to act within the scope and limits of his or her authority as designated by a court or other agreement. A legal representative acting outside of his or her authority or scope must meet the definition of designated representative.

(a) For an individual under the age of 18, the legal representative is the parent, unless a court appoints another person or agency to act as the guardian; and

(b) For an individual 18 years of age or older, the legal representative is the guardian appointed by a court order or an agent legally designated as the health care representative, where the court order or the written designation provides authority for the appointed or designated person to make the decisions indicated where the term "legal representative" is used.

(108) "Mandatory Reporter":

(a) Means:

(A) Any public or private official as defined in ORS 419B.005 who comes in contact with a child with or without an intellectual or developmental disability and has reasonable cause to believe the child has suffered abuse, or comes in contact with any person whom the public or private official has reasonable cause to believe abused the child, regardless of whether or not the knowledge of the abuse was gained in the official capacity of the public or private official;

(B) Any public or private official as defined in ORS 430.735 who, while acting in an official capacity, comes in contact with an adult with an intellectual or developmental disability and has reasonable cause to believe the adult has suffered abuse, or comes in contact with any person whom the public or private official has reasonable cause to believe abused the adult;

(C) Any public or private official as defined in ORS 124.050 who comes in contact with an older adult, age 65 and older, and has reasonable cause to believe the older adult has suffered abuse, or comes in contact with any person whom the public or private official has reasonable cause to believe abused the older adult; and

(D) Any public or private official as defined in ORS 441.630 who comes in contact with a resident of a nursing facility and has reasonable cause to believe the resident has suffered abuse, or comes in contact with any person whom the public or private official has reasonable cause to believe abused the resident.

(b) Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this definition, 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.

(109) "Mechanical Restraint" means any mechanical device, material, object, or equipment attached or adjacent to the body of an individual that the individual cannot easily remove or easily negotiate around that restricts freedom of movement or access to the body of the individual. Mechanical restraint is not:

(a) The use of acceptable infant safety products;

(b) The use of car safety systems, consistent with applicable state law for people without disabilities; or

(c) Safeguarding equipment when ordered by a physician or health care provider and approved by the ISP team.

(110) "Medicaid Agency Identification Number" means the numeric identifier assigned by the Department to a provider following the enrollment of the provider as described in OAR chapter 411, division 370.

(111) "Medicaid Performing Provider Number" means the numeric identifier assigned by the Department to an entity or person following the enrollment of the entity or person to deliver Medicaid funded services as described in OAR chapter 411, division 370. The Medicaid Performing Provider Number is used by the rendering provider for identification and billing purposes associated with service authorizations and payments.

(112) "Medicaid Title XIX (OHP) Benefit Package" means only the Medicaid benefit packages provided under OAR 410-120-1210(4)(a) and (b). This excludes individuals receiving CHIP Title XXI benefits.

(113) "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.

(114) "Monitoring" means the periodic review of the implementation of services and supports identified in an Individual Support Plan or Annual Plan, and the quality of services delivered by other organizations.

(115) "Natural Support" means:

(a) For a child, the parental responsibilities for the child and the voluntary resources available to the child from the relatives, friends, neighbors, and the community of the child that are not paid for by the Department.

(b) For an adult, the voluntary resources available to an adult from the relatives, friends, significant others, neighbors, roommates, and the community of the adult that are not paid for by the Department.

(116) "Notice of Involuntary Reduction, Transfer, or Exit" means form APD 0719DD. This form is part of the AFH/DD Mandatory Written Notice of Exit or Transfer.

(117) "Notification of Planned Action" means form APD 0947. The Notification of Planned Action is the written decision notice issued to an individual in the event that a developmental disabilities service is denied, reduced, suspended, or terminated.

(118) "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.

(119) "Nursing Facility Level of Care" means a child:

(a) Has a documented medical condition that demonstrates the need for active treatment as assessed by the Clinical Criteria as defined in OAR chapter 411, division 300; and

(b) The medical condition requires the care and treatment of services normally provided in a nursing facility.

(120) "Nursing Service Plan" means the plan that is developed by a registered nurse based on an initial nursing assessment, reassessment, or an update made to a nursing assessment as the result of a monitoring visit.

(a) The Nursing Service Plan is specific to a child and identifies the diagnoses and health needs of the child and any service coordination, teaching, or delegation activities.

(b) The Nursing Service Plan is separate from the ISP as well as any service plans developed by other health professionals.

(121) "Nursing Tasks" mean the care or services that require the education and training of a licensed professional nurse to perform. Nursing tasks may be delegated.

(122) "OAAPI" means the Department of Human Services, Office of Adult Abuse Prevention and Investigation.

(123) "OAH" means "Office of Administrative Hearings".

(124) "OCCS Medical" means medical programs under the "Office of Client and Community Services" as defined under OAR 410-200-0015. OCCS medical insurance may be Medicaid Title XIX or CHIP Title XXI as described under OAR 410-200-0305 through 410-200-0510.

(125) "ODDS" means the Department of Human Services, Office of Developmental Disabilities Services.

(126) "OIS" means "Oregon Intervention System".

(127) "OHA" means "Oregon Health Authority".

(128) "OHP" means "Oregon Health Plan".

(129) "Older Adult" means an adult at least 65 years of age.

(130) "Oregon Intervention System" is the system of providing training of elements of positive behavior support and non-aversive behavior intervention. The Oregon Intervention System uses principles of pro-active support and describes approved protective physical intervention techniques that are used in an emergency to maintain health and safety.

(131) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(132) "Oregon Supplemental Income Program-Medical" is Oregon Medicaid insurance coverage for individuals who meet the eligibility criteria described in OAR chapter 461.

(133) "Parent" means the biological parent, adoptive parent, or stepparent of a child. Unless otherwise specified, references to parent also include a person chosen by the parent or guardian to serve as the designated representative of the parent or guardian in connection with the provision of ODDS funded supports.

(134) "Person-Centered Planning":

(a) Means a timely and formal or informal process driven by an individual, includes people chosen by the individual, ensures the individual directs the process to the maximum extent possible, and enables the individual to make informed choices and decisions consistent with 42 CFR 441.540.

(b) Person-centered planning includes gathering and organizing information to reflect what is important to and for the individual and to help:

(A) Determine and describe choices about personal goals, activities, services, providers, service settings, risks, 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.

(c) The methods for gathering information vary, but all are consistent with the cultural considerations, needs, and preferences of the individual.

(135) "Personal Agent" means a person who:

(a) Is a case manager for the provision of case management services;

(b) Is the person-centered plan coordinator for an individual as defined in the Community First Choice State Plan Amendment;

(c) Works directly with individuals and, if applicable, the legal or designated representatives and families of individuals to provide or arrange for support services as described in these rules; and

(d) Meets the qualifications set forth in OAR 411-340-0150(5).

(136) "Personal Support Worker":

(a) Means a person:

(A) Who has a Medicaid provider number.

(B) Hired by an individual with an intellectual or developmental disability or the representative of the individual.

(C) Who receives money from the Department for the purpose of providing services to an individual in the home or community of the individual.

(D) Whose compensation for providing services is provided in whole or in part through the Department, CDDP, CIIS, or Support Services Brokerage.

(b) This definition of personal support worker is intended to be interpreted consistently with ORS 410.600.

(137) "Plan Year" means 12 consecutive months from the start date specified on an authorized ISP or Annual Plan.

(138) "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 intrusive intervention possible;

(c) Ensures that abusive or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(139) "Prescription Medication" means any medication that requires a prescription from a physician before the medication may be obtained from a pharmacist.

(140) "Primary Caregiver" means:

(a) For a child, the parent, guardian, relative, or other non-paid parental figure of a child that normally provides direct care to the child. In this context, the term parent or guardian may include a designated representative.

(b) For an adult, the person identified in an Individual Support Plan as providing the majority of services and support for an individual in the home of the individual.

(141) "Primary Care Provider" means the health care provider who delivers day-to-day comprehensive health care. Typically, the primary care provider acts as the first contact and principal point of continuing care for an individual within the health care system and coordinates other specialist care that the individual may need.

(142) "Private Duty Nursing" means the State Plan nursing services described in OAR chapter 410, division 132 (OHA, Private Duty Nursing Services) and OAR 411-350-0055 that are determined medically necessary to support an individual aged 18 through 20.

(143) "PRN (pro re nata)" means the administration of a medication to an individual on an 'as needed' basis.

(144) "Productivity" as defined in ORS 427.005 means regular engagement in income-producing work, preferable competitive employment with supports and accommodations to the extent necessary, by an individual that is measured through improvements in income level, employment status, or job advancement or engagement by an individual in work contributing to a household or community.

(145) "Progress Note" means a written record of an action taken by provider in the delivery of a service to support an individual. A progress note may also be a recording of information related to services, support needs, or circumstances of the individual which is necessary for the effective delivery of services.

(146) "Protection" means the necessary actions offered to an individual as soon as possible to prevent subsequent abuse or exploitation of the individual, to prevent self-destructive acts, or to safeguard the person, property, and funds of the individual.

(147) "Protective Physical Interventions" are safety procedures utilized with an individual that assists in keeping the individual protected from harming themselves or others through supportive measures, as taught in the Oregon Intervention System.

(148) "Protective Services" mean the necessary actions offered to an individual as soon as possible to prevent subsequent abuse or exploitation of the individual, to prevent self-destructive acts, or to safeguard the person, property, and funds of the individual.

(149) "Provider" means a person, agency, organization, or business that is approved by the Department or other appropriate agency and selected by an individual, designated or legal representative to provide Department-funded services. The provider for a child may not also be the primary caregiver of the child.

(150) "Provider Agency" means a public or private community organization that delivers developmental disabilities services and is certified and endorsed by the Department under the rules in OAR chapter 411, division 323 or division 340, that:

(a) Is primarily in business to provide supports for individuals eligible to receive developmental disabilities;

(b) Provides supports for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the person who actually provides support for the individual.

(151) "Provider Owned, Controlled, or Operated Setting" means:

(a) The provider is responsible for delivering home and community-based services to individuals in the setting and the provider:

(A) Owns the setting;

(B) Leases or co-leases the residential setting; or

(C) If the provider has a direct or indirect financial relationship with the property owner, the setting is presumed to be provider controlled or operated.

(b) A setting is not provider-owned, controlled, or operated if the individual leases directly from a third party that has no direct or indirect financial relationship with the provider.

(c) When an individual receives services in the home of a family member, the home is not considered provider-owned, controlled, or operated.

(152) "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.

(153) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services.

(154) "Relief Care" means the service that is provided on a periodic basis for the relief of, or due to the temporary absence of, a person normally available to provide supports to an individual. A unit of service of relief care is 24 hours. It is available through the Community First Choice State Plan Amendment

(155) "Request for Service" means:

(a) Submission of a completed application for developmental disabilities services as described in OAR 411-320-0080;

(b) A written request for a new developmental disabilities service or provider; or

(c) A written request for a change in a developmental disabilities service currently provided.

(156) "Residency Agreement" means the written and legally enforceable agreement between a residential provider and an individual or the legal or designated representative of the individual when the individual is receiving home and community-based services in a provider owned, controlled, or operated residential setting. The Residency Agreement identifies the rights and responsibilities of the individual and the residential provider and provides the individual protection from eviction substantially equivalent to landlord-tenant laws.

(157) "Residential Programs" means services delivered by:

(a) 24-hour residential programs described in OAR chapter 411, division 325;

(b) Adult foster homes described in OAR chapter 411, division 360;

(c) Supported living programs described in OAR chapter 411, division 328; and

(d) Foster homes for children described in OAR chapter 411, division 346.

(158) "Residential Settings" mean the location where individuals who get services from a residential program live.

(159) "Restraint" means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal functioning of an individual.

(160) "Review" means a request for reconsideration of a decision.

(161) "Safeguarding Equipment" means a device used to provide support to an individual for the purpose of achieving and maintaining func-

tional body position, proper balance, and protecting the individual from injury or symptoms of existing medical conditions.

(162) "School Aged" means the age at which an individual is old enough to attend kindergarten through high school.

(163) "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.

(164) "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, 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 the help of a social support network if needed, to control resources in order to purchase support services;

(c) Autonomy. The arranging of resources and personnel, both formal and informal, that assists an individual to live a life in the community rich in community affiliations; and

(d) Responsibility. The acceptance of a valued role of an individual in the 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 the individual.

(165) "Self-Direction" means that an individual, or as applicable the legal or designated representative of the individual, has decision-making authority over services and takes direct responsibility for managing services with the assistance of a system of available supports that promotes personal choice and control over the delivery of waiver and state plan services.

(166) "Sensory Impairment" means loss or impairment of sight or hearing from any cause, including involvement of the brain.

(167) "Service Agreement":

(a) Is the written agreement consistent with an ISP that describes at a minimum:

(A) Supports 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 their own safety and the individual is missing while in the community.

(b) For employed personal support workers, the service agreement serves as the written job description for Oregon Home Care Commission purposes.

(c) For non-personal support worker providers, the ISP when signed by the provider serves as the service agreement.

(168) "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 supports, or family support.

(169) "Service Level" means the amount of attendant care, skills training services, or personal care as described in OAR chapter 411, division 034, determined necessary by a functional needs assessment and made available to meet the identified support needs of an individual.

(170) "Service Record" means the combined information related to an individual.

(171) "Services Coordinator" means an employee of the Department, CDDP, or other agency that contracts with the county or Department who provides case management services. A services coordinator acts as the proponent for individuals with intellectual or developmental disabilities and is the person-centered plan coordinator for the individual as defined in the Community First Choice State Plan Amendment.

(172) "Setting" means the community-based location where services are delivered.

(173) "Sheltered Workshop" means a facility in which individuals with intellectual or developmental disabilities are congregated for the purpose of receiving employment services and performing work tasks for pay at the facility. A sheltered workshop primarily employs individuals with intellectual and developmental disabilities, or other disabilities, with the exception of service support staff. A sheltered workshop is a fixed site that is owned, operated, or controlled by a provider, where an individual has few or no opportunities to interact with individuals who do not have disabilities, not including paid support staff. A sheltered workshop is not small group employment in an integrated employment setting, and is not otherwise an integrated employment setting.

(174) "Significant Other" means a person selected by an individual to be the friend of the individual.

(175) "Skills Training" means the hourly service that is intended to increase the independence of an individual through training, coaching, and prompting the individual to accomplish ADL, IADL, and health-related skills. Skills training is available through the Community First Choice State Plan Amendment.

(176) "Social Benefit" means that developmental disabilities services are intended to assist an individual to function in society on a level comparable to that of a person who does not experience a developmental disability.

(a) Social benefits may not:

(A) Duplicate benefits and services otherwise available to a person regardless of disability;

(B) Replace normal parental responsibilities for the services, education, recreation, and general supervision of a child;

(C) Except as described in OAR chapter 411, division 435 for transition services, provide financial assistance with food, clothing, shelter, and laundry needs common to any person; or

(D) Replace other governmental or community services available to an individual.

(b) Assistance provided as a social benefit is reimbursement for an expense previously authorized in an ISP.

(c) Assistance provided as a social benefit may not exceed the actual cost of the support required by an individual to be supported in the home of the individual.

(177) "Staff" means a paid employee who is responsible for providing services and supports to individuals and whose wages are paid in part or in full with funds sub-contracted with a Community Developmental Disabilities Program, Brokerage, or contracted directly through the Department.

(178) "Substantiated" means an abuse investigation has been completed by the Department or the designee of the Department and the preponderance of the evidence establishes the abuse occurred.

(179) "Support" means:

(a) For a child, the assistance that a child and a family requires, solely because of the effects of a condition that makes the child eligible for developmental disabilities, to maintain or increase the age-appropriate independence of the child, achieve age-appropriate community presence and participation of the child, and to maintain the child in the family home. Support is subject to change with time and circumstances.

(b) For an adult, the assistance that an adult individual requires, solely because of the effects 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.

(180) "Transfer" means movement of an individual from one service setting to a different service setting administered or operated by the same provider.

(181) "Transition-Age" means:

(a) Not older than 24 years of age.

(b) Not younger than 14 years of age. With respect to Vocational Rehabilitation Services, persons who are under 16 years of age may receive employment services with Department approval. With respect to ODDS, persons who are under 18 years of age may receive employment services with Department approval.

(182) "Unacceptable Background Check" means an administrative process that produces information related to the background of a person that precludes the person from being an independent provider for one or more of the following reasons:

(a) Under OAR 407-007-0275, the person applying to be an independent provider has been found ineligible due to ORS 443.004;

(b) Under OAR 407-007-0275, the person was enrolled as an independent provider for the first time, or after any break in enrollment, after July 28, 2009 and has been found ineligible due to ORS 443.004; or

(c) A background check and fitness determination has been conducted resulting in a "denied" status as defined in OAR 407-007-0210.

(183) "Unusual Incident" means any incident involving an individual that includes serious illness or an accident, death, injury or illness requiring inpatient or emergency hospitalization, a suicide attempt, when an individ-

ual contacts the police or is contacted by the police, a fire requiring the services of a fire department, an act of physical aggression, or any incident requiring an abuse investigation.

(184) "Variance" means the temporary exemption from a regulation or provision of the rules that may be granted by the Department upon written application.

(185) "Volunteer" means any person assisting a provider without pay to support the services and supports provided to an individual.

(186) "Workday" means 12:00 AM through 11:59 PM.

(187) "Work Week" means 12:00 AM Sunday through 11:59 PM Saturday,

(188) "Written Outcome" means the written response from the Department or the local program to a complaint following a review of the complaint.

(189) "Young Adult" means a young individual aged 18 through 20.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 409.050
Hist.: APD 22-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 39-2014, f. 12-26-14, cert. ef. 12-28-14; APD 40-2014, f. 12-26-14, cert. ef. 12-28-14; APD 38-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 26-2016, f. & cert. ef. 6-29-16

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Rule Caption: ODDS: Community Living Supports
Adm. Order No.: APD 27-2016
Filed with Sec. of State: 6-29-2016
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Notice Publication Date: 5-1-2016
Rules Adopted: 411-450-0010, 411-450-0020, 411-450-0030, 411-450-0040, 411-450-0050, 411-450-0060, 411-450-0070, 411-450-0080, 411-450-0100
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is adopting rules for community living supports in OAR chapter 411, division 450 to include the eligibility requirements, service descriptions, service limits, and provider qualifications for attendant care, relief care, and skills training available under the Community First Choice1915(k) funding authority. These rules were taken from portions of current rules located in OAR chapter 411, divisions 300, 308, 330, 340, 350, and 355. The relevant portions of those rules are being eliminated and consolidated into this new division. This will assure that variation within rules across program areas related to these services are eliminated.

The Department is also incorporating new sections into OAR chapter 411, division 450 that were not in prior rules, including:

- A financial eligibility requirement that an individual with a certain amount of home equity is ineligible for community living supports.

- Authority for the Department to deny services when the services are unable to adequately meet the needs of the individual or when the setting in which services are delivered is not safe for the individual or provider.

- Requiring agency providers to notify the Department when the provider intends to change operations in a way that multiple individuals will lose services.

- Adaptations to any rules that are impacted by OAR chapter 411, division 004 related to home and community-based requirements for facility-based services.

- The provision for these rules to be used as the basis for an agency endorsement as described in OAR chapter 411 division 323.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-450-0010
Statement of Purpose

(1) The rules in OAR chapter 411, division 450 prescribe standards, responsibilities, and procedures for the delivery of community living supports. Supports are intended to permit individuals to live independently in a community-based setting.

(2) Community living supports are designed to prevent out-of-home placement of a child, or to return a child to the family home from a residential setting other than the family home.

(3) These rules prescribe service eligibility requirements for individuals receiving community living supports, and standards and procedures for agency providers operating a community living supports program.

(4) The rules in OAR chapter 411, division 450 effectuate Oregon's Employment First policy under which the employment of individuals with developmental disabilities in competitive integrated employment is the highest priority over unemployment, segregated employment, or other non-work day activities. The delivery of services provided under these rules presumes all individuals eligible for services are capable of working in an integrated employment setting and earning minimum wage or better.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 27-2016, f. & cert. ef. 6-29-16

411-450-0020
Definitions and Acronyms

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 450:

(1) "ADL" means "Activities of Daily Living".

(2) "CDDP" means "Community Developmental Disabilities Program".

(3) "Facility-Based" means a service that is operated at a fixed site owned, operated, or controlled by a service provider where an individual has few or no opportunities to interact with people who do not have a disability except for paid staff.

(4) "Family":

(a) Means a unit of two or more people that includes at least one individual, found to be eligible for developmental disabilities services, where the primary caregiver is:

(A) A family member as defined in OAR chapter 411, division 317; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general, such as child-rearing, maintenance of the residence, and basic living expenses; and

(iii) Joint responsibility for supporting the individual when the individual 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 determining the service eligibility of an individual for community living supports as a resident in the family home.

(5) "Functional Needs Assessment":

(a) Means the comprehensive assessment or re-assessment that:

(A) Documents physical, mental, and social functioning;

(B) Identifies risk factors and support needs; and

(C) Determines the service level as defined in OAR 411-317-0000, including the maximum number of hours that may be authorized.

(b) The functional needs assessment required for an adult to access community living supports is known as the Adult Needs Assessment (ANA). The Department incorporates Version C of the ANA into these rules by this reference. The ANA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/.

(c) The functional needs assessment required for a child to access community living supports is known as the Children's Needs Assessment (CNA). The Department incorporates Version C of the CNA into these rules by this reference. The CNA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/.

(d) A printed copy of the assessment tool may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

(6) "IADL" means "Instrumental Activities of Daily Living".

(7) "In-Home Expenditure Guidelines" mean the guidelines published by the Department that describe allowable uses for Department funds. Effective January 1, 2015, the Department incorporates Version 2.0 of the In-home Expenditure Guidelines into these rules by this reference. The In-home Expenditure Guidelines are maintained by the Department at: http://www.oregon.gov/dhs/dd/adults/ss_exp_guide.pdf. A printed copy may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(8) "ISP" means "Individual Support Plan".

(9) "OCCS" means the "Oregon Health Authority, Office of Client and Community Services".

(10) "OHP" means "Oregon Health Plan".

(11) "OSIPM" means "Oregon Supplemental Income Program-Medical".

(12) "Primary Caregiver" means the person identified in an ISP as providing the majority of service and support for an individual in the home of the individual.

(13) "PSW" means "Personal Support Worker".

(14) "These Rules" mean the rules in OAR chapter 411, division 450.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 27-2016, f. & cert. ef. 6-29-16

411-450-0030
Eligibility for Community Living Supports

(1) An individual may not be denied community living supports 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) To be eligible for community living supports, an individual must:

(a) Be an Oregon resident.

(b) Be determined eligible for developmental disabilities services by the CDDP of the county of origin as described in OAR 411-320-0080, except for those enrolled in the Medically Involved Children's Waiver or the Medically Fragile Children's Program as described in OAR chapter 411, division 300.

(c) Choose to use a case management entity for assistance with design and management of developmental disabilities services.

(d) Be receiving a Medicaid Title XIX (OHP) benefit package through OSIPM or OCCS medical program.

(A) An adult is eligible for community living supports if the adult had been receiving community living supports as a child up to the 18th birthday and has not become ineligible due to section (2)(d)(B) of this rule.

(B) Eligibility for community living supports based on section (2)(d)(A) of this rule ends if:

(i) The individual does not apply for a disability determination and Medicaid within 10 business days of his or her 18th birthday;

(ii) The Social Security Administration or the Presumptive Medicaid Disability Determination Team of the Department finds that the individual does not have a qualifying disability; or

(iii) The individual is determined by the state of Oregon to be ineligible for a Medicaid Title XIX (OHP) benefit package through OSIPM or OCCS medical program.

(C) Individuals receiving Medicaid OHP under OCCS medical coverage for services in a nonstandard living arrangement as defined in OAR 461-001-0000 are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(i) The transfer of assets as set forth in OAR 461-140-0210 to 461-140-0300; and

(ii) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(e) Be determined to meet the level of care defined in OAR 411-415-0020.

(f) POST ELIGIBILITY TREATMENT OF INCOME Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(g) Participate in a functional needs assessment and provide information necessary to complete the functional needs assessment and reassessment within the time frame required by the Department.

(A) Failure to participate in the functional needs assessment or to provide information necessary to complete the functional needs assessment or reassessment within the applicable time frame results in the denial of service eligibility. In the event service eligibility is denied, a written Notification of Planned Action must be provided as described in OAR chapter 411, division 318.

(B) The Department may allow additional time if circumstances beyond the control of the individual prevent timely participation in the functional needs assessment or timely submission of information necessary to complete the functional needs assessment or reassessment.

(h) A child receiving supports and services under the family support program as described in OAR 411-305-0120 is not eligible to receive community living supports.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 27-2016, f. & cert. ef. 6-29-16

411-450-0040
Community Living Supports Entry and Exit

(1) A provider of community living supports must agree in writing to provide those supports identified in an ISP for the individual. Agreement may be shown by a signature on a Service Agreement. The agreement must include acknowledgement of:

(a) Limits of service that may be provided; and

(b) Payment rate.

(2) An individual must have community living supports terminated:

(a) At the end of a service period agreed upon by all parties and specified in the ISP;

(b) At the oral or written request of the individual or legal representative to end the service relationship;

(c) When the individual has been determined to no longer meet eligibility for community living supports as described in OAR 411-450-0030;

(d) When the case management entity has sufficient evidence to believe that an individual has engaged in fraud or misrepresentation, failed to use resources consistent with the services as agreed upon in the ISP, refused to cooperate with documenting expenses, or otherwise knowingly misused public funds associated with these services; or

(e) When the individual either cannot be located or has not responded following 30 days of repeated attempts by staff of the case management entity to complete ISP development or monitoring activities, including participation in a functional needs assessment. An individual, and as applicable the legal or designated representative of the individual, must participate in a functional needs assessment and provide information necessary to complete the functional needs assessment and reassessment within the time frame required by the Department.

(A) Failure to participate in the functional needs assessment or provide information necessary to complete the functional needs assessment or reassessment within the applicable time frame results in the denial of service eligibility.

(B) The Department may allow additional time if circumstances beyond the control of the individual prevent timely participation in the functional needs assessment or reassessment or timely submission of information necessary to complete the functional needs assessment or reassessment.

(3) INVOLUNTARY REDUCTIONS AND EXITS.

(a) A provider agency must only reduce or exit an individual involuntarily for one or more of the following reasons:

(A) The behavior of the individual poses an imminent risk of danger to self or others;

(B) The individual experiences a medical emergency;

(C) The service needs of the individual exceed the ability of the provider;

(D) The individual fails to pay for services when required to do so; or

(E) The certification or endorsement for the provider agency described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) PROVIDER AGENCY NOTICE OF INVOLUNTARY REDUCTION OR EXIT. A provider agency must not reduce services, transfer, or exit an individual involuntarily without 30 days advance written notice to the individual, the legal or designated representative of the individual (as applicable), and the case manager, 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 the Notice of Involuntary Reduction or Exit form approved by the Department and include:

(i) The reason for the reduction or exit; and

(ii) The right of the individual to a hearing as described in subsection (e) of this section.

(B) A Notice of Involuntary Reduction or Exit is not required when an individual requests the reduction or exit.

(c) A provider may give less than 30 days advance 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, the legal or designated representative of the individual (as applicable), and the case manager immediately upon determination of the need for a reduction, transfer, or exit.

(d) NOTICE OF INVOLUNTARY GROUP REDUCTION, TRANSFER, OR EXIT. If a community living supports provider reduces or transfers more than 10 individuals within any 30 calendar day period, the community living supports provider must provide 60 days advance written notice to the individuals, the Department, the legal or designated representative of the individual (as applicable), and the case manager.

(A) The written notice must be provided on the Notice of Involuntary Reduction, Transfer, or Exit form approved by the Department and include:

(i) The reason for the reduction, transfer, or exit; and

(ii) The right of the individual to a hearing as described in subsection (e) of this section.

(B) A Notice of Involuntary Group Reduction, Transfer, or Exit is not required when an individual requests the reduction, transfer, or exit.

(e) HEARING RIGHTS. An individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0030 to dispute an involuntary reduction or exit. If an individual 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 advance written notice of a reduction, transfer, or exit as described in subsection (c) of this section and the individual has requested a hearing, the provider must reserve service availability for the individual until receipt of the Final Order.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 27-2016, f. & cert. ef. 6-29-16

411-450-0050
Minimum Standard for Community Living Supports

(1) ABUSE PROHIBITED. No adult or child shall be abused and abuse shall not be tolerated by any employee, staff, or volunteer of an individual, agency, or case management entity.

(2) Community living supports, purchased with Department funds, must be provided only as a social benefit.

(3) Community living supports must be delivered 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.

(4) Community living supports must be delivered in accordance with applicable state and federal wage and hour regulations.

(5) For a child, community living supports are considered to be for supports that are not typical for a parent or guardian to provide to a child of the same age.

(6) Community living supports may only be reimbursed when they are consistent with the In-Home Expenditure Guidelines.

(7) Community living supports shall only be reimbursed after community living supports are delivered as identified in an ISP or Service Agreement.

(8) Department funds may not be used for:

(a) A reimbursement to an individual, legal or designated representative, or family member of the individual, for expenses related to services.

(b) An advancement of funds to an individual, legal or designated representative, or family member of the individual, to obtain services.

(c) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 407-045-0260 or OAR chapter 411, division 317.

(d) Services that restrict the freedom of movement of an individual by seclusion in a locked room under any condition.

(e) Vacation costs that are normally incurred by a person on vacation, regardless of disability, and are not strictly required by the need of the individual for ADL, IADL, or health related tasks in all home and community-based settings.

(f) Rate enhancements to existing employment services under OAR chapter 411, division 345.

(g) Services or supports that are not necessary as determined by a functional needs assessment or are not cost-effective.

(h) Services that do not meet the description of community living supports as described in these rules, or that do not meet the definition of social benefits as defined in OAR 411-317-0000.

(i) Educational services for school-age individuals, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills.

(j) Services, activities, materials, or equipment that may be obtained by the individual through other available means, such as private or public insurance, philanthropic organizations, or other governmental or public services.

(k) Services or activities for which the legislative or executive branch of Oregon government has prohibited use of public funds.

(l) Services in circumstances where the case management entity determines there is sufficient evidence to believe that the individual, the legal or designated representative of the individual (as applicable), legal representative, or provider has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP, refused to cooperate with record keeping required to document use of Department funds, or otherwise knowingly misused public funds associated with community living supports.

(m) Services provided in a nursing facility, correctional institution, Behavioral Rehabilitation Services facility, Psychiatric Residential Treatment Services facility, or hospital.

(n) Unless under certain conditions and limits specified in Department guidelines, employee wages or provider agency charges for time or services when the individual is not present or available to receive services, including, but not limited to hourly "no show" charge, and provider travel and preparation hours.

(o) Costs associated with training a PSW, other independent provider, or provider agency staff to deliver services.

(p) After September 1, 2018, services that are not delivered in a home and community-based setting.

(q) Services available to an individual under Vocational Rehabilitation and Other Rehabilitation Services, 29 U.S.C. § 701-796l, as amended.

(r) Services available to an individual under the Individuals with Disabilities Education Act, 20 U.S.C §1400, as amended.

(s) Notwithstanding abuse as defined in ORS 419B.005, services that the case management entity determines are characterized by failure to act or neglect that leads to, or is in imminent danger of causing, physical injury through negligent omission, treatment, or maltreatment of an individual.

(t) Support generally provided for a child of similar age without disabilities by the parent or guardian or other family members.

(u) Supports and services that are funded by child welfare in the family home.

(v) Educational and supportive services provided by schools as part of a free and appropriate public education for children and young adults under the Individuals with Disabilities Education Act.

(w) Home schooling.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 27-2016, f. & cert. ef. 6-29-16

411-450-0060
Community Living Supports

(1) Department funds may be used to purchase community living supports available through the Community First Choice state plan that include:

(a) Attendant care as described in section (2) of this rule;

(b) Skills training as described in section (3) of this rule; and

(c) Relief care as described in section (4) of this rule.

(2) ATTENDANT CARE SERVICES. Attendant care services include direct support provided to an individual in the home of the individual or community by a qualified provider. ADL and IADL services provided through attendant care must be needed to permit individuals to live independently in a community-based setting.

(a) ADL services include, but are not limited to:

(A) Basic personal hygiene — providing or assisting with needs such as bathing (tub, bed, bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene.

(B) Toileting, bowel, and bladder care - assisting to and from the bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, managing menses, cleansing an individual or adjusting clothing related to toileting, emptying a catheter, drainage bag, or assistive device, ostomy care, or bowel care.

(C) Mobility, transfers, and repositioning - assisting with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises.

(D) Eating — assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with adaptive utensils, cutting food, and placing food, dishes, and utensils within reach for eating.

(E) Cognitive assistance or emotional support provided to an individual due to an intellectual or developmental disability - helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive functions.

(b) IADL services include, but are not limited to:

(A) Light housekeeping tasks necessary to maintain an individual in a healthy and safe environment - cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and laundry.

(B) Grocery and other shopping necessary for the completion of other ADL and IADL tasks.

(C) Meal preparation and special diets.

(D) Support with participation in the community:

(i) Support with community participation — assisting an individual in acquiring, retaining, and improving skills to use available community resources, facilities, or businesses, and improving self-awareness and self-control; and

(ii) Support with communication — assisting an individual in acquiring, retaining, and improving expressive and receptive skills in verbal and non-verbal language, social responsiveness, social amenities, and interpersonal skills, and the functional application of acquired reading and writing skills.

(c) Assistance with ADLs, IADLs, and health-related tasks may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete any of the IADL tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal, audio, 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 assistance 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 the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment 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 if the individual is unable to complete the task independently.

(d) For a child, the primary caregiver is expected to be present or available during the provision of attendant care. ADL and IADL services provided through attendant care must support the child to live as independently as appropriate for the age of the child and support, but not supplant, the family in their primary caregiver role.

(3) SKILLS TRAINING. Skills training is specifically tied to accomplishing ADL, IADL, and other health-related tasks as identified by the functional needs assessment and ISP and permit an individual to live independently in a community-based setting.

(a) Skills training may be applied to the use and care of assistive devices and technologies.

(b) Skills training is authorized when:

(A) The anticipated outcome of the skills training, as documented in the ISP, is measurable;

(B) Timelines for measuring progress towards the anticipated outcome are established in the ISP; and

(C) Progress towards the anticipated outcomes are measured and the measurements are evaluated by a case manager no less frequently than every six months, based on the start date of the initiation of the skills training.

(c) When anticipated outcomes are not achieved within the timeframe outlined in the ISP, the case manager must reassess or redefine the use of skills training with the individual for that particular goal.

(d) For a child, the primary caregiver is expected to be present or available during the provision of skills training. ADL and IADL services provided through skills training must support the child to live as independently as appropriate for the age of the child and support, but not supplant, the family in their primary caregiver role.

(e) Skills training may not replace or supplant the services of the educational system in fulfilling its obligation to educate an individual.

(4) RELIEF CARE.

(a) Relief care may not be characterized as daily or periodic services provided solely to allow the primary caregiver to attend school or work. Daily relief care may be provided in segments that are sequential. Daily relief care delivered by a PSW may not exceed seven consecutive days without permission from the Department.

(b) Relief care may be provided in:

(A) The home of the individual;

(B) A licensed or certified setting;

(C) The home of a qualified provider, chosen by the individual or the representative of the individual, that is a safe setting for the individual; or

(D) The community, during the provision of ADL, IADL, health-related tasks, and other supports identified in the ISP for the individual.

(c) No other community living supports may be provided to an individual during the 24-hour unit of daily relief care.

(5) Community living supports may be delivered:

(a) Individually or in a group as indicated by the outcome of the person centered planning process for the individual.

(b) In the home, community, or a facility.

(A) Community living supports are facility-based if delivered at a fixed site outside of the home of the individual that is operated, owned, or controlled by the service provider.

(B) Facility-based community living supports must, at minimum, provide on-going opportunities and encouragement to individuals for going out into the broader community. Providers initially certified or endorsed by the Department or the Oregon Health Authority on or after January 1, 2016, must comply with this requirement prior to being certified and endorsed to provide services under these rules. Existing providers certified and endorsed prior to January 1, 2016, must make measurable progress toward compliance with this requirement, consistent with a department approved transition plan, and be in full compliance with these rules by September 1, 2018.

(6) SETTING LIMITATIONS.

(a) An individual who lives in their own or family home is eligible for community living supports described in these rules for which the individual has an assessed need and the person centered planning process determines to be appropriate unless:

(A) The Department determines that the health and safety of the individual cannot be reasonably assured through the delivery of community living supports; or

(B) Dangerous conditions in the service setting jeopardize the health or safety of the individual or provider, and the individual, or the legal or designated representative of the individual, is unable or unwilling to implement necessary safeguards to minimize the dangers.

(b) An individual enrolled to a residential program, an adult foster home licensed under OAR chapter 411, division 050, or an assisted living facility licensed under OAR chapter 411, division 054 is not eligible for:

(A) Community living supports provided by a personal support worker.

(B) Community living supports delivered in the home of the individual, whether the home is a licensed setting or not.

(C) Relief care.

(c) A child living in a Behavior Rehabilitation Services (BRS) program as described in OAR 410-170-0000 through 410-170-0120, or Psychiatric Residential Treatment Services (PRTS) as defined in OAR 309-022-0100 is not eligible for community living supports.

(7) SERVICE LIMITS.

(a) All community living supports must be authorized in an ISP as described in OAR 411-415-0070.

(b) For an individual residing in their own or family home, the amount of community living supports in any plan year is limited to the service level determined by a functional needs assessment. The functional needs assessment determines:

(A) The total number of hours available to meet identified needs. The total number of hours may not be exceeded without prior approval from the Department. The types of services that contribute to the total number of hours used include:

(i) Attendant care;

(ii) Skills training; and

(iii) State plan personal care service hours as described in OAR chapter 411, division 034.

(B) The need for two staff to be available simultaneously to provide community living supports to the individual. When such a need is identified, the functional needs assessment determines the maximum number of hours two staff may be simultaneously available.

(c) For an individual enrolled in a residential program, an adult foster home licensed under OAR chapter 411, division 050, or an assisted living facility licensed under OAR chapter 411, division 054, any combination of job coaching, supported employment - small group employment support, employment path services, and community living supports must not exceed an average of 25 hours per week.

(d) No more than 14 days of relief care in a plan year are allowed without approval from the Department. Each day of respite services described in and provided under OAR 411-070-0043(5) contributes to the 14-day limit for relief care.

Stat. Auth.: ORS 409.050, 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

Hist.: APD 27-2016, f. & cert. ef. 6-29-16

411-450-0070

Community Living Supports Providers and Provider Requirements

Delivery of community living supports is limited to the following provider types:

(1) A PSW who meets the standards described in OAR chapter 411, division 375.

(a) Except for a PSW delivering supports to a child in a CIIS program, a PSW may not provide more than 50 hours of community living supports per work week, as defined in OAR 411-375-0020, per individual unless the case management entity or the Department has approved an exception. A PSW delivering supports to a child in a CIIS program may not provide more than 40 hours per work week. The 24 hour relief care service does not contribute to the weekly hour limit.

(b) A PSW is not an available provider type when there is not a common law employer as described in OAR 411-375-0070.

(c) A PSW may not provide community living supports to an individual when the PSW and individual reside together unless:

(A) The PSW is a family member;

(B) The PSW does not own or control the property; or

(C) The individual and the PSW have equal homeowner or rental property rights.

(2) A provider agency certified according to OAR chapter 411, division 323 with an endorsement to these rules.

(3) A home health agency with a current license issued under ORS 443.015.

(4) An in-home care agency with a current license issued under ORS 443.315.

(5) A provider organization currently certified under OAR chapter 411, division 340 whose certificate was issued or applied for prior to January 1, 2016.

(6) A provider agency certified under OAR chapter 411, division 323 and endorsed to OAR 411-340-0170 between January 1, 2016 and the adoption of these rules.

(7) An agency certified under OAR chapter 411, division 323 and endorsed to OAR chapter 411, division 328 for supported living programs or to OAR chapter 411, division 325 for 24-hour residential programs or OAR chapter 411, division 345 for employment may provide community living supports without an endorsement to these rules until the agency's certification is renewed following the adoption of these rules.

(8) An adult foster home licensed under OAR chapter 411, division 360.This provider type may only deliver community living supports:

(a) When they are in or based out of the licensed setting. An adult foster home provider may not provide community living supports to an individual in or based out of the individual's home.

(b) To an adult.

(9) A child foster home licensed under OAR chapter 411, division 346. This provider type may only deliver community living supports:

(a) When they are in or based out of the licensed setting. A child foster home provider may not provide community living supports to a child in or based out of the child's home.

(b) To a child.

(10) An agency certified under OAR chapter 411, division 323 and endorsed to OAR chapter 411, division 325 for 24-hour residential programs does not require endorsement to these rules to deliver community living supports when they are in or based out of the licensed setting. A provider of a 24-hour residential program may not provide community living supports to an individual in or based out of the individual's home.

(11) Providers qualified to deliver community living supports under sections (5) though (10) of this rule are subject to OAR 411-450-0040, 411-450-0050, 411-450-0060, and sections (6) through (23) of 411-450-0080 when delivering community living supports.

Stat. Auth.: ORS 409.050, 430.662

Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670

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411-450-0080

Standards for Provider Agencies Delivering Community Living Supports

(1) CERTIFICATION, ENDORSEMENT, AND ENROLLMENT. To be endorsed to operate a community living support program, the agency must have:

(a) A certificate and an endorsement to operate a community living support program as set forth in OAR chapter 411, division 323; and

(b) A Medicaid Agency Identification Number assigned by the Department as described in OAR chapter 411, division 370.

(2) INSPECTIONS AND INVESTIGATIONS. The provider must allow inspections and investigations as described in OAR 411-323-0040.

(3) MANAGEMENT AND PERSONNEL PRACTICES. The provider must comply with the management and personnel practices as described in OAR 411-323-0050.

(4) PERSONNEL FILES AND QUALIFICATION RECORDS. The provider must maintain written documentation of six hours of pre-service training prior to supervising individuals that includes mandatory abuse reporting training, ISPs, and service agreements.

(5) CONFIDENTIALITY OF RECORDS. The provider must ensure the confidentiality of the records for individuals as described in OAR 411-323-0060.

(6) DOCUMENTATION REQUIREMENTS. Unless stated otherwise, all entries required by these rules must:

(a) Be prepared at the time or immediately following the event being recorded;

(b) Be accurate and contain no willful falsifications;

(c) Be legible, dated, and signed by the person making the entry; and

(d) Be maintained for no less than five years.

(7) Providers must maintain progress notes regarding the community living supports provided. The progress note must include, at minimum, the following information regarding the service rendered:

(a) The date and time the service was provided;

(b) The personnel involved; and

(c) Information regarding the nature of the support provided and how the support met an identified ADL or IADL support need or was a health related task.

(8) Progress notes must be made available monthly and upon request by a case management entity.

(9) Failure to furnish written documentation upon the 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 payment.

(10) 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 at least three years after the close of the contract period.

(b) Individual records must be kept for at least seven years.

(11) UNUSUAL INCIDENTS.

(a) A written report that describes any injury, accident, act of physical aggression, or unusual incident involving an individual and a provider agency employee must be prepared at the time of the incident and placed in the individual's service record. The report must include:

(A) Conditions prior to, or leading to, the incident;

(B) A description of the incident;

(C) Staff response at the time; and

(D) Administrative review and follow-up to be taken to prevent recurrence of the injury, accident, physical aggression, or unusual incident.

(b) The agency must notify the case management entity immediately of an incident or allegation of abuse falling within the scope of OAR 407-045-0260.

(c) In the case of a serious illness, injury, or death of an individual, an agency must immediately notify the individual's legal or designated representative, parent, next of kin, and designated contact person, as applicable.

(d) An agency must send copies of incident reports of all potential or suspected abuse or unusual incidents that occur while the individual is receiving services from an agency to the individual's case management entity within five working days of the potential or suspected abuse or unusual incident.

(12) The agency must develop and implement policies and procedures required for administration and operation in compliance with these rules, including, but not limited to:

(a) Individual rights. The agency must have, and implement, written policies and procedures that protect the individual rights described in OAR 411-318-0010 and that:

(A) Provide for individual participation in selection, training, and evaluation of staff assigned to provide services to individuals;

(B) Protect individuals during hours of service from financial exploitation that may include, but is not limited to:

(i) Staff borrowing from or loaning money to individuals;

(ii) Witnessing wills in which the staff or agency may benefit directly or indirectly; or

(iii) Adding the name of the staff member or agency to the bank account or other personal property of the individual without approval of the individual or the legal representative of the individual (as applicable).

(b) Policies and procedures appropriate to scope of service including, but not limited to, those required to meet minimum standards set forth in sections (15) to (22) of this rule and consistent with the ISPs or written service agreements for individuals currently receiving services.

(13) The agency must deliver services according to an ISP or written Service Agreement.

(14) Service rates as authorized in Department payment and reporting systems for individuals authorized to receive in community living supports and paid to providers for delivering services, as described in these rules, shall be based upon the agency fee schedule published by the Department. For an agency offering services to the general public, billings for Medicaid funds may not exceed the customary charges to private individuals for any like item or services charged by the agency.

(15) The agency must maintain a current record for each individual receiving services. The record must include:

(a) The name, current home address, and home phone number of the individual;

(b) A current ISP or written Service Agreement;

(c) Contact information for the legal or designated representative of the individual (as applicable) and any other people designated by the individual to be contacted in case of incident or emergency;

(d) Contact information for the case management entity assisting the individual to obtain services; and

(e) Records of service provided, including type of services, dates, hours, and personnel involved.

(16) The agency must ensure that employees, contractors, and volunteers receive appropriate and necessary training.

(17) Each agency regulated by these rules must be a drug-free workplace.

(18) Agencies that own or lease sites, provide services to individuals at those sites, and regularly have individuals present and receiving services at those sites, must meet the following minimum requirements:

(a) A written emergency plan must be developed and implemented and must include instructions for staff and volunteers in the event of fire, explosion, accident, or other emergency including evacuation of individuals served.

(b) Posting of emergency information:

(A) The telephone numbers of the local fire, police department, and ambulance service, or "911" must be posted by designated telephones; and

(B) The telephone numbers of the agency director and other people to be contacted in case of emergency must be posted by designated telephones.

(c) A documented safety review must be conducted quarterly to ensure that the service site is free of hazards. Safety review reports must be kept in a central location by the agency for three years.

(d) The agency must train all individuals when the individuals begin attending the service site to leave the site in response to an alarm or other emergency signal and to cooperate with assistance to exit the site.

(A) Each agency must conduct an unannounced evacuation drill each month when individuals are present.

(B) Exit routes must vary based on the location of a simulated fire.

(C) Any individual failing to evacuate the service site unassisted within the established time limits set by the local fire authority for the site must be provided specialized training or support in evacuation procedures.

(D) Written documentation must be made at the time of the drill and kept by the agency for at least two years following the drill. The written documentation must include:

(i) The date and time of the drill;

(ii) The location of the simulated fire;

(iii) The last names of all individuals and staff present at the time of the drill;

(iv) The amount of time required by each individual to evacuate if the individual needs more than the established time limit; and

(v) The signature of the staff conducting the drill.

(E) In sites providing services to individuals who are medically fragile or have severe physical limitations, requirements of evacuation drill conduct may be modified. The modified plan must:

(i) Be developed with the local fire authority, the individual or the individual's legal or designated representative (as applicable), and the agency director; and

(ii) Be submitted as a variance request according to OAR 411-450-0170.

(e) The agency must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(f) At least once every three years, the agency must conduct a health and safety inspection.

(A) The inspection must cover all areas and buildings where services are delivered to individuals, including administrative offices and storage areas.

(B) The inspection must be performed by:

(i) The Oregon Occupational Safety and Health Division;

(ii) The agency's worker's compensation insurance carrier;

(iii) An appropriate expert, such as a licensed safety engineer or consultant as approved by the Department; and

(iv) The Oregon Health Authority, Public Health Division, when necessary.

(C) The inspection must cover:

(i) Hazardous material handling and storage;

(ii) Machinery and equipment used at the service site;

(iii) Safety equipment;

(iv) Physical environment; and

(v) Food handling, when necessary.

(D) The documented results of the inspection, including recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider for five years.

(g) The agency must ensure that each service site has received initial fire and life safety inspections performed by the local fire authority or a Deputy State Fire Marshal. The documented results of the inspection, including documentation of recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider for five years.

(h) Direct service staff must be present in sufficient number to meet health, safety, and service needs specified in the individual written agreements of the individuals present. When individuals are present, staff must have the following minimum skills and training:

(A) At least one staff member on duty with CPR certification at all times;

(B) At least one staff member on duty with current First Aid certification at all times;

(C) At least one staff member on duty with training to meet other specific medical needs identified in the individual ISP or service agreement; and

(D) At least one staff member on duty with training to meet other specific behavior intervention needs as identified in individual the ISP or service agreements.

(19) Agencies providing services to individuals that involve assistance with meeting health and medical needs must:

(a) Develop and implement written policies and procedures addressing:

(A) Emergency medical intervention;

(B) Treatment and documentation of illness and health care concerns;

(C) Administering, storing, and disposing of prescription and non-prescription drugs, including self-administration;

(D) Emergency medical procedures, including the handling of bodily fluids; and

(E) Confidentiality of medical records.

(b) Maintain a current written record for each individual receiving assistance with meeting health and medical needs that includes:

(A) Health status as known;

(B) Changes in health status observed during hours of service;

(C) Any remedial and corrective action required and when such actions were taken if occurring during hours of service; and

(D) A description of any known restrictions on activities due to medical limitations.

(c) If providing medication administration when an individual is unable to self-administer medications and there is no other responsible person present who may lawfully direct administration of medications, the agency must:

(A) Have a written order or copy of the written order, signed by a physician or physician designee, before any medication, prescription or non-prescription, is administered;

(B) Administer medications per written orders;

(C) Administer medications from containers labeled as specified per physician written order;

(D) Keep medications secure and unavailable to any other individual and stored as prescribed;

(E) Record administration on an individualized Medication Administration Record (MAR), including treatments and PRN, or "as needed", orders;

(F) Not administer unused, discontinued, outdated, or recalled drugs; and

(G) Not administer PRN psychotropic medication. PRN orders may not be accepted for psychotropic medication.

(d) Maintain a MAR (if required). The MAR must include:

(A) The name of the individual;

(B) The brand name or generic name of the medication, including the prescribed dosage and frequency of administration as contained on physician order and medication;

(C) Times and dates the administration or self-administration of the medication occurs;

(D) The signature of the staff administering the medication or monitoring the self-administration of the medication;

(E) Method of administration;

(F) Documentation of any known allergies or adverse reactions to a medication;

(G) Documentation and an explanation of why a PRN, or "as needed", medication was administered and the results of such administration; and

(H) An explanation of any medication administration irregularity with documentation of a review by the agency director.

(e) Provide safeguards to prevent adverse medication reactions, including:

(A) Maintaining information about the effects and side-effects of medications the agency has agreed to administer;

(B) Communicating any concerns regarding any medication usage, effectiveness, or effects to the individual or the individual's legal or designated representative (as applicable); and

(C) Prohibiting the use of one individual's medications by another individual or person.

(f) Maintain a record of visits to medical professionals, consultants, or therapists if facilitated or provided by the agency.

(20) Agencies that own or operate vehicles that transport individuals must:

(a) Maintain the vehicles in safe operating condition;

(b) Comply with Department of Motor Vehicles laws;

(c) Maintain insurance coverage on the vehicles and all authorized drivers;

(d) Carry a first aid kit in each vehicle; and

(e) Assign drivers who meet applicable Department of Motor Vehicles requirements to operate vehicles that transport individuals.

(21) If assisting with management of funds, the agency must have and implement written policies and procedures related to the oversight of the individual's financial resources that include:

(a) Procedures that prohibit inappropriately expending an individual's personal funds, theft of an individual's personal funds, using an individual's funds for staff's own benefit, commingling an individual's personal funds with the agency's or another individual's funds, or the agency becoming an individual's legal or designated representative.

(b) The agency's reimbursement to the individual of any funds that are missing due to theft or mismanagement on the part of any staff of the agency, or of any funds within the custody of the agency that are missing. Such reimbursement must be made within 10 business days of the verification that funds are missing.

(22) Additional standards for assisting individuals to manage difficult behavior.

(a) The agency must have, and implement, a written policy concerning behavior intervention procedures. The agency must inform the individual, and as applicable the individual's legal or designated representative, of the behavior intervention policy and procedures prior to entry into the community living supports program.

(b) Any intervention to alter an individual's behavior must be based on positive behavioral theory and practice and must be:

(A) Approved in writing by the individual or the individual's legal or designated representative (as applicable); and

(B) Described in detail in the individual's record.

(c) Psychotropic medications and medications for behavior must be:

(A) Prescribed by a physician through a written order; and

(B) Monitored by the prescribing physician for desired responses and adverse consequences.

(23) Additional standards for supports that involve protective physical intervention.

(a) The agency must only employ protective physical intervention:

(A) As part of an individual's ISP;

(B) As an emergency measure, but only if absolutely necessary to protect the individual or others from immediate injury; or

(C) As a health-related protection prescribed by a physician, but only if necessary for individual protection during the time that a medical condition exists.

(b) Agency staff members who need to apply protective physical intervention under an individual's ISP or service agreement must be trained by a Department-approved trainer and documentation of the training must be maintained in the staff members' personnel file.

(c) Protective physical intervention in emergency situations must:

(A) Be only used until the individual is no longer a threat to self or others;

(B) Be authorized by the agency director or the physician of the individual within one hour of application of the protective physical intervention;

(C) Result in the immediate notification of the individual's legal or designated representative (as applicable); and

(D) Prompt a review of the individual's ISP or written service agreement, initiated by the agency, if protective physical intervention is used more than three times in a six month period.

(d) Protective physical intervention must be designed to avoid physical injury to an individual or others and to minimize physical and psychological discomfort.

(e) All use of protective physical intervention must be considered an unusual incident and result in the completion of an incident report as described in OAR 411-450-0080. The report must include:

(A) The name of the individual to whom the protective physical intervention is applied;

(B) The date, type, and length of time of the application of protective physical intervention;

(C) The name and position of the person authorizing the use of the protective physical intervention;

(D) The name of the staff member applying the protective physical intervention; and

(E) Description of the incident.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
Hist.: APD 27-2016, f. & cert. ef. 6-29-16

411-450-0100
Variances

(1) The Department may grant a variance to these rules based upon a demonstration by an agency that an alternative method or different approach provides equal or greater agency effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws.

(2) The agency requesting a variance must submit a written application to the Department that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept, or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) If the variance applies to an individual's service, evidence that the variance is consistent with the individual's current ISP.

(3) The Department's director may approve or deny the request for a variance. The director's decision is final.

(4) The Department must notify the agency of the Department's decision. The decision notice must be sent within 45 calendar days of the receipt of the request by the Department with a copy sent to all relevant Department programs or offices.

(5) The agency may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 430.662
Stats. Implemented: ORS 427.005, 427.007, 430.610, 430.620, 430.662-430.670
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Rule Caption: ODDS: Case Management Services
Adm. Order No.: APD 28-2016
Filed with Sec. of State: 6-29-2016
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Rules Adopted: 411-415-0010, 411-415-0020, 411-415-0030, 411-415-0040, 411-415-0050, 411-415-0060, 411-415-0070, 411-415-0080, 411-415-0090, 411-415-0100, 411-415-0110, 411-415-0120
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is adopting rules in OAR chapter 411, division 415 to streamline the qualifications and related requirements for providers of case management services related to assessments, Individual Support Plans (ISP), and service monitoring.

The rules in OAR chapter 411, division 415 are drawn primarily from the case management and related functions contained in OAR chapter 411, division 320 for Community Developmental Disabilities Programs (CDDPs) and OAR chapter 411, division 340 for Support Services Brokerages and are intended to describe case management services delivered by a CDDP, Brokerage, or the Department through the Children's Intensive In-Home Services Program (CIIS) or the children's residential program.

The rules in OAR chapter 411, division 415 also include standards incorporated into OAR chapter 411, division 320 and 340 by temporary rulemaking on January 1, 2016 relating to home and community-based (HCB) services and settings, person-centered service planning, and conflict free case management.

The rules in OAR chapter 411, division 415 include new language that was not in prior rules, including:

- Authority to make a termination of case management a termination of all other developmental disabilities services.

- Authority for a Brokerage to terminate case management and all other developmental disabilities services.

- A requirement for all case managers to complete core competency training.

- A requirement for a case management entity to complete payment authorization in the Department's payment and reporting system prior to the start of services.

- A requirement for all case management entities to carry out the obligations of family reconnection.

- Adaptation of language and requirements around the new Oregon ISP and processes associated with it.

- Updated expectations around the Career Development Plan.

- Aligned expectations across types of case management providers regarding case management services, including ISP authorizations and the use of service agreements, and the case management entity's role with independent providers.

- A requirement for an annual in home visit for all Department consumers and the authority to terminate services if the visit is not permitted.

- The authority to deny authorization of services when the setting for the delivery of those services is unsafe, or it is not possible for the chosen services to keep the individual safe.

- Updated requirements related to HCBS compliance, including residential and non-residential setting options.

- A rule that specifies the conditions that must be present in order for the Department to make payment for case management services.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-415-0010
Statement of Purpose

(1) The rules in OAR chapter 411, division 415 prescribe standards, responsibilities, and procedures for the delivery of case management services to individuals with intellectual or developmental disabilities.

(2) Providers of case management services are limited to employees of:

(a) A Community Developmental Disabilities Program (CDDP);

(b) A Support Services Brokerage (Brokerage);

(c) Other public or private agencies contracted by a local community mental health authority; or

(d) The Department of Human Services, Office of Developmental Disabilities Services.

(3) Case management services are delivered using person-centered practices to assist individuals in accessing needed medical, employment, social, educational, and other services. Case management services include, but are not limited to:

(a) Assessment and periodic reassessment of individual needs and preferences;

(b) Development and periodic revision of the Individual Support Plan;

(c) Referral and related activities;

(d) Monitoring; and

(e) Follow-up activities.

(4) Services provided under these rules are intended to identify, strengthen, expand, and where required, supplement private, public, formal, and informal support available to individuals with intellectual or developmental disabilities. The case management services described in these rules encourage the exercising of self-determination in the design and direction of the individual receiving services.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
Hist.: APD 28-2016, f. & cert. ef. 6-29-16

411-415-0020
Definitions and Acronyms

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 415:

(1) "Affiliated Entity" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), or a political subdivision or instrumentality, including a municipal corporation of a state, that has an incident of ownership in the CME.

(2) "Case Management Contact" means a reciprocal interaction between a case manager and an individual or the legal or designated representative of the individual (as applicable).

(3) "Case Management Services" mean the functions performed by a case manager that are funded by the Department. Case management services include, but are not limited to:

(a) Assessment of support needs;

(b) Developing an ISP or Annual Plan that may include authorized services;

(c) Information and referral for services; and

(d) Monitoring the effectiveness of services and supports.

(4) "Case Manager" means the person who delivers case management services who meets the qualifications of OAR 411-415-0040 and is employed:

(a) As a personal agent by a Brokerage;

(b) As a services coordinator by a CDDP; or

(c) As a services coordinator by the Department.

(5) "CDDP" means "Community Developmental Disabilities Program".

(6) "CIIS" means "Children's Intensive In-Home Services".

(7) "CME" means "Case Management Entity". A CME means:

(a) A CDDP;

(b) A Brokerage;

(c) CIIS; or

(d) The Department's Children's Residential Program.

(8) "Functional Needs Assessment" means the tool that identifies the needs of an individual that must be addressed to ensure the safety and well-being of the individual and to ensure the individual does not become unnecessarily institutionalized.

(a) A functional needs assessment may be:

(A) The Adult Needs Assessment (ANA). The Department incorporates Version C of the ANA into these rules by this reference. The ANA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm.

(B) The Children's Needs Assessment (CNA). The Department incorporates Version C of the CNA into these rules by this reference. The CNA is maintained by the Department at: http://www.dhs.state.or.us/spd/tools/dd/cm.

(C) The Support Needs Assessment Profile (SNAP). The Department incorporates the SNAP into these rules by this reference. The SNAP is maintained by the Department at: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/PROVIDERS-PARTNERS/Pages/rebar-assessments.aspx.

(D) The Supports Intensity Scale (SIS). The Department incorporates the SIS into these rules by this reference. The SIS is maintained at: http://aaidd.org/sis#.VvwgeaPn_Dc.

(b) A printed copy of the assessment tools may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

(9) "Geographic Service Area" means the area within the state of Oregon where a CME is approved to provide developmental disabilities services. The geographic service area for a CDDP is the county.

(10) "IEP" means "Individualized Education Program".

(11) "Incident of Ownership" means an ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interest.

(12) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in another entity. Indirect ownership interest includes an ownership interest in an entity that has an indirect ownership interest in another entity.

(13) "In-Home Expenditure Guidelines" mean the guidelines published by the Department that describe allowable uses for Department funds. The Department incorporates Version 2.0 of the In-home Expenditure Guidelines into these rules by this reference. The In-home Expenditure Guidelines are maintained by the Department at: http://www.oregon.gov/dhs/dd/adults/ss_exp_guide.pdf. A printed copy may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(14) "Initial ISP" means the first ISP:

(a) For an individual who is newly entered into case management services; or

(b) Following a period when the individual did not have an authorized ISP.

(15) "Initial Level of Care" means the first level of care determination:

(a) For an individual who is newly accessing Community First Choice or waiver services; or

(b) Following a period when the individual was not determined to meet level of care.

(16) "ISP" means "Individual Support Plan".

(17) "Level of Care" means as defined in OAR 411-317-0000:

(a) ICF/IDD Level of Care;

(b) Hospital Level of Care; or

(c) Nursing Facility Level of Care.

(18) "OHP" means "Oregon Health Plan".

(19) "Owner" means a person with an ownership interest.

(20) "Ownership Interest" means the possession of equity in the capital, stock, or profits of an entity.

(21) "SSI" means "Supplemental Security Income".

(22) "These Rules" mean the rules in OAR chapter 411, division 415.

(23) "Transition Period" means the first 60 days after an individual enters a new program type, setting, or CME.

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411-415-0030
Eligibility for Case Management Services — Entry, Exit, Transfers

(1) Individuals determined eligible for developmental disabilities services may not be denied case management 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) To be eligible for case management services, an individual must be determined eligible for developmental disabilities services by a CDDP as described in OAR 411-320-0080.

(a) An adult who is eligible for case management services who lives in his or her own or family home may select to have case management services provided by a CDDP or a Brokerage, when the Brokerage has the capacity to provide the service according to OAR 411-340-0110. When a local Brokerage is selected, but the local Brokerage does not have the capacity to provide case management, case management must be delivered by the local CDDP until the local Brokerage has capacity.

(b) A child or adult selecting services from a residential program may only have case management services delivered by a CDDP or the Department.

(c) A child who is eligible for and receives family support services as described in OAR chapter 411, division 305 may only have case management services delivered by a CDDP.

(d) A child who is eligible for and enrolled in a CIIS program as described in OAR chapter 411, division 300 may only have case management services delivered by the Department, and by the CDDP with respective roles identified in the ISP.

(e) In order to receive case management services, an individual, or as applicable the legal representative of the individual, must accept the following supports:

(A) Assistance from a CME with the design and management of Department-funded services and supports;

(B) Abuse investigations;

(C) The presence of a case manager at required entry or exit meetings;

(D) Monitoring of services (when applicable) in accordance with OAR 411-415-0090;

(E) Case management contacts as described in OAR 411-415-0090; and

(F) Case manager access to the service record.

(3) To be eligible for case management services delivered by a CIIS services coordinator, an individual must meet the eligibility requirements for a CIIS program in OAR 411-300-0120 and be enrolled to the program.

(4) ENTRY INTO CASE MANAGEMENT.

(a) The county of origin must enter an individual who is eligible for developmental disabilities services into case management services.

(b) Upon entry into case management services, the CME must provide an explanation of the individual rights described in OAR 411-318-0010 to the individual and if applicable the legal representative of the individual.

(c) The CME must assure the availability of a case manager to address the support needs of the individual and any emergency or crisis. The CME must appropriately document the assignment of the case manager in the service record for the individual and the CME must accurately report entry into case management services in the Department payment and reporting systems.

(A) Within 10 business days from the date of entry, the CME must send a written notice to the individual, and as applicable the legal representative of the individual, that includes the name, telephone number, and location of the case manager assigned to the individual.

(B) The CME must ask the individual, and as applicable the legal representative of the individual, to identify any family and other advocates to whom the CME must provide the name, telephone number, and location of the case manager.

(5) EXIT FROM CASE MANAGEMENT.

(a) A CME retains responsibility for providing case management services to an individual until the responsibility is terminated and the individual exits from case management services as described in this rule.

(b) A CME must exit an individual from case management services when any of the following occur:

(A) The individual, or as applicable the legal representative of the individual, submits a signed written request terminating case management services, or such a request is made by telephone and documented in the service record for the individual.

(B) The individual dies.

(C) The individual is determined to be ineligible for:

(i) Developmental disabilities services in accordance with OAR 411-320-0080; or

(ii) CIIS in accordance with OAR chapter 411, division 300.

(D) The individual moves out of Oregon.

(E) The individual moves out of the geographic service area of the CME. If an individual takes up residence in another geographic service area, a CME that operates in the new geographic service area may enter the individual into case management services.

(i) If an individual receiving case management from a CDDP moves to a new geographic service area, the original CDDP may continue to provide case management services to the individual. The individual, or as applicable the legal or designated representative of the individual, must request to retain case management services from the original CDDP, and both the original CDDP and the CDDP in the new location must agree in writing to the responsibilities for delivering case management services.

(ii) If an adult individual receiving case management from a Brokerage moves to a new geographic service area, the Brokerage may continue to provide case management services. The adult individual, or as applicable the legal or designated representative of the individual, must request to retain case management services from the original Brokerage, and the Department must approve. Approval may be granted if the Brokerage is available to meet the case management standards described in

OAR 411-415-0050 timely and adequately and the Brokerage has the capacity to deliver the case management services.

(iii) In the case of a child moving into a foster home or 24-hour residential program, the county of parental residency or court jurisdiction must retain responsibility for case management services unless:

(I) The child is entering into a state operated group home; or

(II) An agreement between the CDDPs and the legal representative of the child is reached that describes the responsibilities for case management services.

(F) After the individual either cannot be located or has not responded after a minimum of 30 days of repeated attempts by CME staff to complete ISP development, annual plan development, or monitoring activities, including participation in a functional needs assessment.

(c) An exit from case management services is an exit from all developmental disabilities services, except in the case of a move by an individual within the state, but out of the geographic service area of the CME.

(d) When an individual is being exited from case management services, the CME must issue a Notification of Planned Action consistent with OAR 411-318-0020 to notify the individual, and as applicable the legal representative of the individual, of the intent of the CME to terminate case management services and any other developmental disabilities services. A Notification of Planned Action is not required when the exit from case management is due to:

(A) The death of the individual; or

(B) A move by the individual within the state, but out of the geographic service area of the CME.

(e) When a child is exited from a CIIS program, the child may be entered into a CDDP for case management services if the child is eligible for developmental disabilities services according to OAR 411-320-0080.

(6) CHANGE OF CASE MANAGEMENT SERVICES PROVIDER.

(a) An available CME, chosen by the individual, or as applicable the legal or designated representative of the individual, must enter an eligible individual into the CME within 10 days of a request to change the CME unless a later date is mutually agreed upon by the individual, or as applicable the legal or designated representative of the individual, and the CMEs involved in the change. The agreement must be documented in the service record by the CME of the individual at the time of the agreement.

(b) A change in CME may only be to a CDDP or Brokerage that is within the same geographic service area as the residence of the individual, unless an exception is approved by the Department.

(c) The exiting CME must assure all relevant information is provided to the entering CME to assist the entering CME in implementing an ISP or Annual Plan that best meets the support needs of the individual, including, but not limited to:

(A) A current application on the Department-mandated application;

(B) A copy of the level of care determination, if present;

(C) A copy of the current functional needs assessment, if present;

(D) A copy of the eligibility determination;

(E) Copies of financial eligibility information;

(F) Copies of any legal documents, such as guardianship papers, conservatorship, civil commitment status, probation, and parole;

(G) Copies of progress notes; and

(H) A copy of the current ISP or Annual Plan, and any protocols, provider service agreements, behavior support, and nursing plans.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
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411-415-0040
Case Manager Staff Requirements

(1) CASE MANAGER. The case manager must have knowledge of the public service system for developmental disabilities services in Oregon and at least:

(a) A bachelor's degree in behavioral science, social science, or a closely related field;

(b) A bachelor's degree in any field and one year of human services related experience, such as work providing assistance to people and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing;

(c) An associate's degree in a behavioral science, social science, or a closely related field and two years of human services related experience, such as work providing assistance to people and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or

(d) Three years of human services related experience, such as work providing assistance to people and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing.

(2) CASE MANAGER TRAINING. The case manager must participate in a core competency training sequence approved by the Department. The core competency training sequence is not a substitute for the normal procedural orientation that must be provided by the CME to the new case manager.

(a) The orientation provided by the CME to a new case manager must include:

(A) An overview of the role and responsibilities of a case manager.

(B) An overview of developmental disabilities services and related human services within the geographic service area of the CME.

(C) An overview of the Department's rules governing the CME.

(D) An overview of the Department's administrative rules, policies, and expenditure guidelines for services and service providers that may be authorized by the CME.

(E) An overview of the enrollment process and required documents needed for enrollment into the Department's payment and reporting systems.

(F) A review and orientation of Medicaid, SSI, Social Security Administration, home and community-based waiver and state plan services, OHP, and the individual support planning processes for the services they coordinate.

(G) A review (prior to having contact with individuals) of the case manager's responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, older adults, individuals with physical disabilities, and children.

(b) The case manager must participate in an on-line series of required case management core competency modules as follows:

(A) A case manager hired after the adoption of these rules must complete:

(i) Tier 1 trainings within 30 days of the employment start date and before working unassisted.

(ii) Tier 2 trainings within 90 days of the employment start date.

(B) Other case managers must complete core competency modules as directed by the Department.

(c) Within the first year, the case manager must attend or participate in ISP training that is endorsed or sponsored by the Department.

(d) The case manager must continue to enhance his or her knowledge, as well as maintain a basic understanding of developmental disabilities services, self-determination, person-centered thinking and practices, and the skills, knowledge, and responsibilities necessary to perform the duties of the position. Each case manager 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.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
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411-415-0050
Standards for Case Management Services

(1) The CME must apply the principles of self-determination and person-centered practices to provision of case management services.

(2) The CME must ensure that a case manager is available to provide case management services and other supports to the individual.

(a) Case management services include the activities related to:

(A) Assessment and periodic reassessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services including those assessments described in OAR 411-415-0060.

(B) Development and periodic revision of an ISP or Annual Plan based on the information collected through an assessment or reassessment that specifies the desired outcomes, goals, and actions to address the medical, employment, social, educational, and other services needed by the eligible individual as described in OAR 411-415-0070.

(C) Accessing available services, including referral and related activities to help an individual obtain needed services as described in OAR 411-415-0080.

(D) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the ISP or Annual Plan is effectively

implemented and adequately addresses the needs of the eligible individual as described in OAR 411-415-0090.

(b) Other supports provided by a CME may include, but are not limited to:

(A) Authorizing services in the Department's electronic payments and reporting system;

(B) Arranging employer-related supports that may include, but are not limited to:

(i) Education about employer responsibilities;

(ii) Orientation to basic wage and hour issues; and

(iii) Use of common employer-related tools, such as service agreements.

(C) Assisting the Department with establishing provider credentials; and

(D) Assistance with understanding and accessing financial, medical, and other benefits.

(3) At least annually and at the request of the individual, or as applicable the legal representative of the individual, the CME must provide an explanation of the individual rights described in OAR 411-318-0010 to the individual and if applicable the legal representative of the individual.

(4) A CME may not authorize services that are delivered by an affiliated entity.

(5) Developmental disabilities services must be authorized in accordance with OAR 411-415-0070. A case manager must authorize any developmental disabilities service chosen by the individual, or as applicable the legal or designated representative of the individual, for which the individual is eligible as described in the relevant program rules.

(a) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disabilities service is denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(b) HEARINGS.

(A) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(B) An individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025.

(c) Upon entry into case management, upon request, and annually thereafter, a notice of hearing rights and the policy and procedures for hearings as described in OAR chapter 411, division 318 must be explained and provided to an individual, and as applicable the legal or designated representative of the individual.

(6) Services authorized in an ISP must be entered into the Department's payment and reporting system within 30 days of the start of the services being delivered by any individual provider.

(7) If an individual loses eligibility for a Medicaid Title XIX (OHP) Benefit Package, a case manager must assist the individual to identify why the eligibility was lost. Whenever possible, the case manager must assist the individual in reestablishing the eligibility. The case manager must document the assistance given in the service record for the individual.

(8) A case manager must participate in the delivery of protective services for adults and children when required by Oregon Administrative Rule or Oregon Revised Statute.

(9) CHOICE ADVISING. Through choice advising, the CME must assure that case management and other developmental disabilities service options, provider options, and setting options, including non-disability specific settings and an option for a private or shared unit in a residential program, are described to all individuals receiving case management services from the CME, or to the legal representative of the individual.

(a) An individual newly determined eligible for developmental disabilities services must receive choice advising prior to or concurrent with the initial level of care determination.

(b) Choice advising occurs as part of the person-centered planning process and must be conducted prior to an initial ISP and prior to a review of the ISP when required according to OAR 411-415-0070(3).

(c) Choice advising must occur at least six months before the18th birthday of a child.

(d) If a CME is affiliated with an agency provider of developmental disabilities services in addition to case management services, the CME must disclose the relationship and inform the individual, or as applicable the legal or designated representative of the individual, that the CME cannot authorize the affiliated provider. The CME must discuss other case management provider options when the individual, or as applicable the legal or designated representative of the individual, expresses interest in receiving services from the affiliated provider.

(10) A case manager must coordinate services with the child welfare caseworker assigned to a child to ensure the provision of required supports from the Department, CDDP, and child welfare.

(11) The case manager must participate in transition planning by attending IEP meetings or other transition planning meetings for students 16 years of age or older to discuss the transition of the student to adult living and work situations, unless the attendance of the case manager is refused by the parent or guardian of the student or the student if the student is 18 years or older. The case manager must participate in transition planning as young as age 14, if transition planning deemed appropriate by the student's IEP team, unless the attendance of the case manager is refused by the parent or guardian of the student or the student if the student is 18 years or older.

(12) When appropriate, a case manager must coordinate with vocational rehabilitation regarding employment services. When appropriate, a case manager must facilitate referrals to vocational rehabilitation.

(13) A services coordinator at a CDDP 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.

(14) A services coordinator at a CDDP must participate in the appointment of the health care representative of an individual as described in OAR chapter 411, division 365.

(15) The CME must implement procedures to address individual, designated representative, or family complaints regarding service delivery that have not been resolved using the complaint procedures (informal or formal) of a provider agency. The complaint procedures must be consistent with the requirements in OAR 411-318-0015.

(16) A case manager must coordinate with other state, public, and private agencies regarding services to individuals.

(17) When appropriate, a case manager must facilitate referrals to nursing facilities as described in OAR 411-070-0043.

(18) A case manager must coordinate and monitor the services provided to an eligible individual living in a nursing facility.

(19) A Department case manager must make referrals for entry and participate in all entry meetings for children in residential programs, CIIS, and the Stabilization and Crisis Unit.

(20) The CME must provide case management services to individuals who are eligible for and desire them. If an individual receiving case management services from a CDDP is receiving other developmental disabilities 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.

(21) CHANGE OF CASE MANAGER.

(a) If the CME changes the assignment of a case manager for any reason, the CME must notify the individual, the legal and designated representative of the individual (as applicable), and all providers within 10 business days of the change. The notification must be in writing and include the name, telephone number, email address, and mailing address of the new case manager.

(b) The individual receiving services, or as applicable the legal or designated representative of the individual, may request a new case manager within the same CME or request a change of case management entity.

(22) FAMILY RECONNECTION. The CME and a case manager 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 an individual who is currently receiving developmental disabilities services.

(a) If a family member contacts the CME for assistance in locating an individual, the CME must refer the family member to the Department. A family member may contact the Department directly.

(b) The Department shall send the family member a Department form requesting further information to be used in providing notification to the individual. The form shall include 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 shall determine:

(A) If the individual was previously a resident of Fairview Training Center or Eastern Oregon Training Center;

(B) If the individual is deceased or living;

(C) Whether the individual is currently or previously enrolled in Department services; and

(D) The county in which services are being provided, if applicable.

(d) With permission from the individual, the Department shall notify the family member if the individual is enrolled or no longer enrolled in Department services within 10 business days from the receipt of the request.

(e) If the individual is enrolled in Department services, the Department shall send the completed family information form to the individual and the case manager.

(f) If the individual is deceased, the Department shall follow the process for identifying the personal representative of the individual as provided for in ORS 192.526.

(A) If the personal representative and the requesting family member are the same, the Department shall inform the personal representative that the individual is deceased.

(B) If the personal representative is different from the requesting family member, the Department shall contact the personal representative for permission before sharing information about the individual with the requesting family member. The Department must make a good faith effort to find the personal representative and obtain a decision concerning the sharing of information as soon as practicable.

(g) When an individual is located, the CME must facilitate a meeting with the individual to discuss and determine if the individual wishes to have contact with the family member.

(A) The case manager must assist the individual 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 may support contact or present a risk to the individual.

(B) If the individual does not have a legal representative or is unable to express his or her wishes, the ISP team of the individual must be convened to review factors and choose the best response for the individual after evaluating the situation.

(h) If the individual 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 does not wish to have contact, the CME 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 must be within 60 business days from the receipt of the information form from the family member.

(k) The decision by the individual is not appealable.

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411-415-0060
Assessment and Reassessment Activities

(1) LEVEL OF CARE DETERMINATION.

(a) A case manager must assure that an individual has an initial level of care determination prior to accessing Community First Choice state plan or waiver services. The level of care determination must be made using a Department prescribed form based on a face to face contact. An initial level of care determination must be submitted to the Department within 30 days of the date the individual or legal representative signed the completed level of care determination.

(b) A case manager must assure that a level of care determination is reviewed for every individual receiving Community First Choice state plan or waiver services:

(A) Within 12 months from the previous annual review:

(i) The first annual review must be completed no later than 12 months from the date of the approval of the Diagnosis and Evaluation Coordinator (D & E Coordinator).

(ii) The annual review date may be reset for a date earlier than 12 months from the date of the approval of the D & E Coordinator, but no later than 12 months from the date of the review of the D & E Coordinator.

(B) No earlier than 60 days prior to the implementation of a renewed ISP.

(C) Any time there is a significant change in a condition that qualified the individual for the level of care.

(c) When a case manager completes an initial level of care determination, the case manager must ensure that an individual enrolled to a Medicaid Title XIX (OHP) Benefit Package is:

(A) Offered and advised of all services available for which the individual is eligible including, but not limited to, the choice of institutional or home and community-based services.

(B) Provided a Notification of Rights (form APD 0948).

(d) The occasion of the level of care determination must be documented in a progress note in the service record for the individual, including that the determination was made based on a face to face contact with the individual.

(2) FUNCTIONAL NEEDS ASSESSMENT. A case manager must assure a functional needs assessment is conducted initially and at least annually for each individual who has or is expected to have an ISP.

(a) The functional needs assessment must be completed:

(A) Within 45 days from the date that the individual submitted a completed application or the date the CME learns of the eligibility of the individual for a Medicaid Title XIX (OHP) Benefit Package;

(B) Prior to the authorization of an initial ISP;

(C) No earlier than 60 days prior to the annual renewal of an ISP; and

(D) Within 45 days from the date an individual, or as applicable the legal or designated representative of the individual, requests a new functional needs assessment.

(b) The functional needs assessment must include a face to face contact with the individual by the assessor.

(c) The Department, at the discretion of the Department, may conduct or assign an alternate assessor to conduct the functional needs assessment in lieu of a case manager.

(d) No fewer than 14 days prior to conducting a functional needs assessment, the CME must mail a notice of the assessment process to the individual to be assessed. The notice must include a description and explanation of the assessment process and an explanation of the process for appealing the results of the assessment.

(3) An assessment for State Plan Personal Care must be completed by the case manager as described in OAR 411-034-0070.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
Hist.: APD 28-2016, f. & cert. ef. 6-29-16

411-415-0070
Service Planning

(1) PRINCIPLES FOR SERVICE PLANNING. This rule prescribes standards for the development and implementation of an ISP or Annual Plan. An ISP must:

(a) Be developed based on assessed need using a person-centered process consistent with OAR 411-004-0030(1) and in a manner that addresses issues of independence, integration, and provides opportunities to seek employment and work in competitive integrated employment settings, in order to assist individuals to establish outcomes, plan for supports, and review and redesign support strategies.

(b) Be designed to enhance the quality of life of the individual.

(c) Be consistent with the following principles:

(A) Adult individuals have the right to make informed choices about the level of family member participation.

(B) The preferences of the individual and the family of a child must serve to guide the ISP team. The case manager must facilitate active participation of the individual throughout the planning process.

(C) Barriers. The planning process is designed to identify the types of services and supports necessary to achieve the preferences of an individual and the family of a child, identify the barriers to providing those preferred services, and develop strategies for reducing the barriers.

(D) Specify cost-effective arrangements for obtaining the required supports and applying public, private, formal, and informal resources available to the eligible individual.

(E) When planning for a child in a 24-hour residential program or foster care, the following must apply:

(i) Unless contraindicated, there must be a goal for family reunification;

(ii) The number of moves or transfers must be kept to a minimum; and

(iii) Unless contraindicated, if the placement of a child is distant from the family of the child, the case manager must continue to seek a placement that brings the child closer to the family.

(2) INDIVIDUAL SUPPORT PLANS (ISP). An individual enrolled in waiver or Community First Choice state plan services must have an ISP, completed on a Department approved document, that is consistent with the outcome of the person centered planning process and OAR 411-004-0030(2).

(a) The initial ISP:

(A) May begin a transition period; and

(B) Must be authorized no more than 90 days from the date a completed application is submitted to the CDDP as described in OAR 411-320-0080.

(b) An initial ISP has a duration of twelve full months, beginning the month following the authorization of the ISP.

(c) The duration of an annual ISP may not exceed 12 months. A new start date for an ISP may be established within the 12 months, with the consent of the individual, or as applicable the legal or designated representative of the individual, when the individual enters or exits:

(A) A 24-hour residential program as described in OAR chapter 411, division 325. A transfer to a new setting within a program may not cause a new start date for an ISP.

(B) A supported living program as described in OAR chapter 411, division 328. A transfer to a new setting within a program may not cause a new start date for an ISP.

(C) A foster care home as described in OAR chapter 411, divisions 346 or 360.

(D) A CIIS program.

(d) During a transition period, the ISP must include the minimum necessary services and supports for an individual upon entry to a new program type, setting, or CME. The ISP during a transition period must include, at a minimum, an authorization of necessary services, the supports needed to facilitate adjustment to the services offered, the supports necessary to ensure health and safety, and the assessments and consultations necessary for further ISP development.

(e) All Department funded developmental disabilities services included in an ISP must be consistent with the ISP manual, Department policy, and the In-Home Expenditure Guidelines when applicable.

(f) For Community First Choice state plan and waiver services, the supports included in an ISP must address a need that has been determined to be necessary by a functional needs assessment and the identified goals and preferences of the individual.

(g) An initial or annual ISP authorized to begin on or after March 1, 2017 must include any individually-based limitations as described in OAR 411-004-0040. All individually-based limitations must be included in the ISP no later than February 28, 2018.

(h) A Career Development Plan must be completed as part of the ISP:

(A) When the individual is working-age; or

(B) Prior to the expected exit from school for students eligible for services under the Individuals with Disabilities Education Act (I.D.E.A.). If a student leaves school prior to the expected exit, the student must have the opportunity to have a Career Development Plan within one year of the unexpected exit.

(i) The Career Development Plan must:

(A) For individuals who use employment services under OAR chapter 411, division 345, include goals and objectives related to obtaining, maintaining, or advancing in competitive integrated employment, or, at minimum, exploring competitive integrated employment or developing skills that may be used in competitive integrated employment.

(B) Be developed based on a presumption that, with the right support and job match, the individual may succeed and advance in an integrated employment setting and earn minimum wage or better.

(C) Prioritize competitive integrated employment in the general workforce.

(D) For an individual who has competitive integrated employment, person-centered service planning must focus on maintaining employment, maximizing the number of hours an individual works consistent with his or her preferences and interests, improving wages and benefits, and promoting additional career or advancement opportunities.

(E) For an individual using job coaching or job development services, the Career Development Plan must document either a goal or discussion regarding opportunities for maximizing work hours and other career advancement opportunities. The recommended standard for planning job coaching and job development is the opportunity to work at least 20 hours per week. Individualized planning should ultimately be based on individual choice, preferences, and circumstances, and recognizes that some individuals may choose to pursue working full time, part time, or another goal identified by the individual.

(F) Document all employment service options presented, including the option to use employment services in a non-disability specific setting, meaning a setting that is not owned, operated, or controlled by a provider of home and community-based services.

(G) For individuals who use employment services in sheltered workshop settings, the Career Development Plan must document that the individual has been encouraged to choose a community-based employment service option and not a sheltered workshop setting option.

(j) Not more than two weeks after authorization, the CME must provide a copy of the most current ISP to the individual, the legal and designated representative of the individual (as applicable), and others as identified by the individual. The ISP must be made available using language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual receiving services and the people important in supporting the individual. When an authorized ISP must be translated from English, translation must be initiated within two weeks of authorization and the translated document must be provided to the individual by the CME upon receipt.

(3) ISP REVIEWS.

(a) An ISP must be reviewed, revised, and authorized as needed:

(A) No more than 30 days following a new functional needs assessment;

(B) Prior to the expiration of the ISP;

(C) No later than the end of a transition period;

(D) When the circumstances or needs of an individual change significantly; and

(E) At the request of an individual or as applicable the legal or designated representative of the individual.

(b) For an individual who changes CME, but remains in an in-home setting, the ISP authorized by the previous CME may be used as authorization for available services for the new CME for up to 60 days when the services in the new setting remain appropriate services.

(4) TEAM PROCESS IN PERSON-CENTERED PLANNING. This section applies to an ISP developed for an individual receiving services in a residential program:

(a) The ISP is developed by the individual, the legal or designated representative of the individual (as applicable), and the services coordinator. Others may be included as a part of the ISP team at the invitation of the individual and as applicable the legal or designated representative of the individual. In order to assure adequate planning, provider representatives are necessary informants to the ISP team, even when they are not ISP team members.

(b) In circumstances where an individual is unable to express his or her opinion or choice using words, behaviors, or other means of communication and the individual does not have a legal or designated representative:

(A) The ISP team is empowered to make a decision on behalf of the individual that the ISP team feels best meets the health, safety, and assessed needs of the individual.

(B) Consensus amongst ISP team members is prioritized. When consensus may not be reached, majority agreement is used. For purposes of reaching a majority agreement each interested party, which may be represented by more than one person, is considered as one member of the ISP team. Interested parties may include, but are not limited to, the provider, family, CME, and designated representative.

(C) No one member of an ISP team has the authority to make decisions for the ISP team.

(c) Any objections to decisions of the ISP team by a member of the ISP team must be documented in the ISP.

(d) A services coordinator must track the ISP timelines and coordinate the resolution of complaints and conflicts arising from ISP discussions.

(5) ISP AUTHORIZATION.

(a) An initial and annual ISP must be authorized prior to implementation.

(b) A revision to an initial or annual ISP that involves the types of developmental disabilities services paid using Department funds must be authorized prior to implementation.

(c) A revision to an initial or annual ISP that does not involve the types of developmental disabilities services using Department funds does not require authorization. Documented agreement to the revision by the individual, or as applicable, the legal or designated representative of the individual, is required prior to implementation of the revision.

(d) An initial ISP, and a revision to an initial or annual ISP requiring authorization, is authorized on the date that:

(A) The signature of the individual, or as applicable the legal or designated representative of the individual, is present on the ISP or documentation is present explaining the reason an individual who does not have a legal or designated representative may be unable to sign the ISP.

(i) Acceptable reasons for an individual without a legal or designated representative not to sign the ISP include physical or behavioral inability to sign the ISP.

(ii) Unavailability is not an acceptable reason for an individual, or as applicable the legal or designated representative of an individual, not to sign the ISP.

(iii) In the case of a revision to an 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 oral agreement may substitute for a signature for up to 10 business days.

(B) The signature of the case manager involved in the development of, or revision to, the ISP is present on the ISP.

(e) A renewing ISP that has been signed as described in this section is authorized to begin the first day after the previous ISP expired.

(f) After September 1, 2018, newly authorized developmental disabilities services may only be authorized to occur in a setting that is consistent with OAR 411-004-0020. By March 17, 2019, all authorized developmental disabilities services must occur in a setting that is consistent with OAR-004-0020.

(g) Community First Choice state plan and waiver services are only funded by the Department when the services are authorized on an ISP developed in a manner consistent with this rule.

(h) A legal or designated representative responsible for directing the development of the ISP on behalf of the individual (as applicable) may not be authorized to be a paid provider for the individual.

(i) An ISP must not authorize any single personal support worker to be paid for more than 50 hours per week per individual unless the CME or the Department has approved an exception. Relief care service does not contribute to the 50 hour limit.

(j) The CME may not authorize a service provider, setting, or a combination of services selected by an eligible individual or the representative of the individual when:

(A) The setting has dangerous conditions that jeopardize the health or safety of the individual and necessary safeguards cannot be taken to improve the setting;

(B) Services cannot be provided safely or adequately by the service provider based on:

(i) The extent of the service needs of the individual; or

(ii) The choices or preferences of the eligible individual or as applicable the legal or designated representative of the individual.

(C) Dangerous conditions in the service setting jeopardize the health or safety of the service provider that is authorized and paid for by the Department, and necessary safeguards cannot be taken to minimize the dangers; or

(D) The individual does not have the ability to make an informed decision, does not have a designated representative to make decisions on his or her behalf, and the Department or CME cannot take necessary safeguards to protect the safety, health, and welfare of the individual.

(k) The case manager must present the individual, or as applicable the legal or designated representative of the individual, with information on service alternatives and provide assistance to assess other choices when the service provider or service setting selected by the individual, or as applicable the legal or designated representative of the individual, is not authorized.

(l) The ISP for an adult enrolled in foster care under OAR chapter 411, division 360, must include at least six hours of activities each week that are of interest to the individual that do not include television or movies made available by the provider. Activities are those available in the community and made available or offered by the provider or the CDDP.

(A) Activities may include:

(i) Recreational and leisure activities; and

(ii) Other activities required to meet the needs of an individual as described in the ISP for the individual.

(B) Activities that contribute to the six hours may not include:

(i) Rehabilitation;

(ii) Educational services; or

(iii) Employment services.

(m) DEVELOPMENTAL DISABILITIES SERVICE AUTHORIZATIONS.

(A) Services may not be authorized when:

(i) The individual does not meet the service eligibility requirements in the program rule corresponding to the service.

(ii) The case manager is not permitted to conduct a monitoring visit to the home as required in OAR 411-415-0090(3)(d).

(B) A services coordinator employed by a CDDP, or a sub-contractor of a CDDP contracted to deliver case management, may authorize an eligible individual to receive the following developmental disabilities services:

(i) Community First Choice 1915(k) state plan services.

(ii) Services described in the ICF/IDD Comprehensive 1915(c) waiver.

(iii) State Plan Personal Care as described in OAR chapter 411, division 034.

(iv) Home delivered meals as described in OAR chapter 411, division 40.

(v) Private duty nursing as described in OAR chapter 410, division 132 and OAR 411-300-0150.

(C) A personal agent may authorize an eligible individual to receive the following developmental disabilities services:

(i) Community First Choice 1915(k) state plan services, except services delivered as part of a residential program.

(ii) Services described in the Support Services 1915(c) waiver.

(iii) State Plan Personal Care as described in OAR chapter 411, division 034.

(iv) Home delivered meals as described in OAR chapter 411, division 40.

(v) Private duty nursing as described in OAR chapter 410, division 132 and OAR 411-300-0150.

(D) A CIIS services coordinator may authorize an eligible individual to receive the following developmental disabilities services:

(i) Community First Choice 1915(k) state plan services.

(ii) Services described in the following 1915(c) waivers:

(I) Medically Involved Children's Waiver;

(II) Medically Fragile (Hospital) Model Waiver; and

(III) Behavioral (ICF/IDD) Model Waiver.

(iii) State Plan Personal Care as described in OAR chapter 411, division 034.

(iv) Private duty nursing as described in OAR chapter 410, division 132 and OAR 411-300-0150.

(E) The Department authorizes entry for children into residential programs, CIIS, and the Stabilization and Crisis Unit.

(6) ANNUAL PLANS. Individuals enrolled in case management services, but not accessing Community First Choice state plan or waiver services must have an Annual Plan.

(a) A case manager must develop an Annual Plan within 90 days of the enrollment of an individual into case management services, and annually thereafter if the individual is not enrolled in any Community First Choice state plan or waiver services.

(b) An Annual Plan must be developed as follows:

(A) For an adult, a written Annual Plan must be documented as an Annual Plan or as a comprehensive progress note in the service record for the individual and consist of:

(i) A review of the current living situation of the individual;

(ii) A review of the employment status of the individual and a summary of any related support needs;

(iii) A review of any personal health, safety, or behavioral concerns;

(iv) A summary of the support needs of the individual; and

(v) Actions to be taken by the case manager and others.

(B) For a child receiving family support services, a services coordinator must coordinate with the child and the family or guardian of the child in the development of an Annual Plan. The Annual Plan for a child receiving family support services must be in accordance with OAR 411-305-0080.

(c) ANNUAL PLAN UPDATES. An Annual Plan must be kept current. A case manager must ensure that a current Annual Plan is maintained for each individual receiving services.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
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411-415-0080
Accessing Developmental Disabilities Services

(1) A CME is required to:

(a) Provide assistance in finding and arranging resources, services, and supports.

(b) Provide information and technical assistance to an individual, and as applicable the legal or designated representative of the individual, in order to make informed decisions. This may include, but is not limited to, information about support needs, settings, programs, and types of providers.

(c) Provide a brief description of the services available from the CME, including typical timelines for activities, required assessments, monitoring and other activities required for participation in a Medicaid program, and the planning process.

(d) Inform the individual, or as applicable the legal or designated representative of the individual, of any potential conflicts of interest between the CME and providers available to the individual.

(e) Inform providers of the responsibility:

(A) To carry out their duty as mandatory reporters of suspected abuse; and

(B) To immediately notify anyone specified by the individual of any incident that occurs when the provider is providing services when the incident may have a serious effect on the health, safety, physical, or emotional well-being, or level of services required.

(2) LICENSED OR CERTIFIED RESIDENTIAL PLACEMENT SETTING OPTIONS. In accordance with ORS 427.121, a case manager must present at least three appropriate licensed or certified residential setting options, including at least two different types of settings, to an adult individual eligible for and desiring to receive services in a licensed or certified residential setting, or to the legal representative, prior to the entry of the adult individual into a licensed or certified residential setting. The case manager is not required to present the licensed or certified residential placement setting options if:

(a) The case manager demonstrates that three appropriate licensed or certified residential placement settings or two different types of settings are not available within the geographic area where the individual wishes to reside;

(b) The individual selects a licensed or certified residential placement setting option and waives the right to be presented with other licensed or certified residential setting options; or

(c) The individual has an imminent risk to health or safety in the current licensed or certified residential setting.

(3) In accordance with the rules for home and community-based services in OAR chapter 411, division 004, an individual, or as applicable the legal or designated representative of the individual, must be advised regarding non-residential service options including employment services and non-residential community living supports. For services considered, a non-disability specific setting option must be presented and documented in the person-centered service plan.

(4) WRITTEN INFORMATION REQUIRED. A case manager must give the relevant content from the ISP that is necessary to for each provider to deliver the services the provider is authorized to deliver, prior to the start of services. The content must include the relevant risks identified in a risk identification tool. The risks are relevant when they may reasonably be expected to threaten the health and safety of the individual, the provider, or the community at large without appropriate precautions during the delivery of the service authorized for the provider to deliver. If an individual, or as applicable the legal representative of the individual, refuses to disclose the information, the CME must disclose the refusal to the provider, who may choose to refuse to deliver the services.

(a) The necessary information is conveyed on a Department approved Service Agreement containing the required content.

(b) For agency operators of a residential program or employment program, the case manager must provide to the agency:

(A) A document indicating safety skills, including the ability of the individual to evacuate from a building when warned by a signal device and adjust water temperature for bathing and washing;

(B) A brief written history of any behavioral challenges, including supervision and support needs;

(C) A record of known communicable diseases and allergies;

(D) Copies of protocols, the risk tracking record or risk identification tool, and any support documentation (if applicable);

(E) Copies of documents relating to health care representation; and

(F) A copy of the most recent Behavior Support Plan and assessment, Nursing Service Plan, and mental health treatment plan (if applicable).

(c) In addition to sub-section (b) of this section, residential programs must be given:

(A) A copy of the eligibility determination document;

(B) A medical history and information on health care supports that includes (when available):

(i) The results of the most recent physical exam;

(ii) The results of any dental evaluation;

(iii) A record of immunizations;

(iv) A record of major illnesses and hospitalizations; and

(v) A written record of any current or recommended medications, treatments, diets, and aids to physical functioning.

(C) A copy of the most recent functional needs assessment. If the needs of an individual have changed over time, the previous functional needs assessments must also be provided;

(D) Copies of documents relating to the guardianship or conservatorship, power of attorney, court orders, probation and parole information, or any other legal restrictions on the rights of the individual (if applicable);

(E) Written documentation that the individual is participating in out-of-residence activities, including public school enrollment for individuals less than 21 years of age; and

(F) A copy of any completed and signed forms documenting consent to an individually-based limitation described in OAR 411-004-0040. The form must be signed by the individual, or, if applicable the legal representative of the individual.

(d) In addition to sub-section (b) of this section, agency providers of employment services must be given:

(A) The Career Development Plan.

(B) Protocols that are necessary to assure the health and safety of the individual.

(e) When an individual is known to be accessing Vocational Rehabilitation services, the Vocational Rehabilitation counselor must be given the Career Development Plan.

(f) If the individual is being entered into a residential program from the family home and the information required in subsection (b) and (c) of this section is not available, the case manager must ensure that the residential program provider assesses the individual upon entry for issues of immediate health or safety.

(A) The case manager must develop and document a plan to secure the information listed in subsection (a) of this section no later than 30 days after entry.

(B) The plan must include a written justification as to why the information is not available and a copy of the plan must be given to the provider at the time of entry.

(5) ENTRY MEETING. No later than the date of entry of an individual into a residential program, a case manager must convene a meeting of the ISP team to review referral material in order to determine appropriateness of entry. An entry meeting may be held for entry into services other than a residential program when a member of the ISP team requests one. A potential provider may request an entry meeting and may refuse entry to an individual who refuses to permit one. Findings of the entry meeting must be recorded in the service record for the individual and distributed to the ISP team members. The findings 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.

(c) The date determined to be the date of entry.

(d) Documentation of the participants included in the entry meeting;

(e) Documentation of information required by section (4) of this rule when entering a residential program.

(f) Documentation of the decision to serve the individual requesting services.

(6) TRANSFER MEETING. A meeting of the ISP team must precede any transfer of an individual that was not initiated by the individual, or as applicable the legal representative of the individual, unless the individual declines to have a meeting. Findings of the transfer meeting must be recorded in the service record for the individual 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 as applicable the legal or designated representative or family members of the individual, may not be honored.

(g) Documentation of the decision regarding the transfer, including verification of the voluntary decision to transfer or a copy of the Notice of Involuntary Reduction, Transfer, or Exit.

(h) The written plan for services for the individual after transfer.

(7) EXIT MEETING. A case manager must offer the individual, and legal or designated representative, an opportunity to convene the ISP team prior to an exit of an individual from a residential program or from agency provided employment services. Findings of the exit meeting must be recorded in the service record for the individual and include, at a minimum:

(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 exit of the individual from services, unless the individual or legal representative is requesting the exit.

(f) Documentation of the decision regarding the exit of the individual, including verification of the voluntary decision to exit or a copy of the Notice of Involuntary, Reduction, Transfer, or Exit.

(g) The written plan for services for the individual after the exit.

(h) Requirements for an exit meeting may be waived if an individual is immediately removed from the applicable program under the following conditions:

(A) The individual or legal representative requests an immediate exit from the program; 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.

(8) When services are provided by an independent provider:

(a) The case manager must provide the individual, and as applicable the designated representative of the individual, a brief description of the responsibilities for use of public funds.

(b) Using a Department approved service agreement, the CME must inform an independent provider engaged to provide supports of:

(A) The type and amount of services authorized in the ISP for the independent provider to deliver; and

(B) Behavioral, medical, known risks, and other information about the individual that is required for the provider to safely and adequately deliver services to the individual.

(c) When an individual or designated representative chooses to receive services from an independent provider, the CME must assure that a person is identified to act as a common law employer for the independent provider consistent with OAR 411-375-0055.

(A) The CME may require intervention as defined in OAR 411-375-0055.

(B) The CME may deny a request for an employer representative if the requested employer representative has:

(i) A history of substantiated abuse or neglect of an adult as described in OAR 407-045-0250 to 407-045-0370;

(ii) A history of founded abuse or neglect of a child as described in OAR 413-015-1000;

(iii) Participated in billing excessive or fraudulent charges; or

(iv) Failed to meet the employer responsibilities described in OAR 411-375-0055, including previous termination as a result of failing to meet the employer.

(C) The CME shall mail a notice informing the individual, and as applicable the legal or designated representative of the individual, when:

(i) The CME denies, suspends, or terminates an employer from performing the employer responsibilities described in 411-375-0055; and

(ii) The CME denies, suspends, or terminates an employer representative from performing the employer responsibilities because the employer representative does not meet the qualifications of an employer representative.

(D) If an individual, or as applicable the legal or designated representative or employer representative of the individual, is dissatisfied with the decision of the CME, the individual, or as applicable the legal or designated representative or employer representative of the individual, may request an administrator review by the Department as described in OAR 411-375-0070.

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411-415-0090
Case Management Contact and Monitoring of Services

(1) CASE MANAGEMENT CONTACT. Every individual who has an ISP must have a case management contact no less than once every three months. Individuals with three or more significant health and safety risks as identified in the Risk Identification Tool, or if determined to be necessary by the case manager, must have monthly case management contact. At least one case management contact per year must be face to face. If an individual or legal representative agrees, other case management contact may be made by telephone or by other interactive methods. The outcome of the case management contact must be recorded in the progress notes. The purpose of the case management contact is:

(a) To assure known health and safety risks are adequately addressed;

(b) To assure that the support needs of an individual have not significantly changed; and

(c) To assure that an individual and designated representative is satisfied with the current supports.

(2) MONITORING OF SERVICES: A case manager must conduct monitoring activities using the framework described in this section.

(a) A case manager is required to provide assistance to the individual or the legal or designated representative with monitoring and improving the quality of supports.

(b) For all individuals with an ISP that authorizes waiver or Community First Choice state plan services, monitoring must include an assessment of the following:

(A) Are services being provided as described in the ISP and do the services result in the achievement of the identified action plans?

(B) Are the personal, civil, and legal rights of the individual protected in accordance with OAR chapter 411, division 318?

(C) Are the personal desires of the individual, and as applicable the legal or designated representative or family of the individual, addressed?

(D) Do the services authorized in the ISP continue to meet the assessed needs of the individual and what is important to, and for, the individual?

(E) Do identified desired outcomes and associated goals and action plans remain relevant and are the goals supported and being met?

(F) Are technological and adaptive equipment and environmental modifications being maintained and used as intended?

(G) Have changing needs or availability of other resources altered the need for continued use of Department funds to purchase supports?

(H) Are the services delivered in a setting that is in compliance with OAR 411-004-0020(1)?

(c) For an individual receiving employment services, the case manager must:

(A) Assess the progress of the individual toward competitive integrated employment; and

(B) When an individual is receiving facility based employment path services, visit each setting at least twice per plan year, while the individual is present, to verify and document the progress being made to support the individual to achieve employment goals documented in the Career Development Plan. Visits must occur no less than once every six months.

(d) When an individual or legal representative has consented to an individually-based limitation, service monitoring must include an evaluation of the ongoing need for the limitation.

(e) Unless specified in these rules, the minimum frequency of service monitoring must be determined by the needs of an individual.

(f) For an individual receiving only case management services and not enrolled in any other funded developmental disabilities services, the case manager 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, a progress note in the service record must document how contact was achieved.

(B) 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 case manager must maintain contact in accordance with planned actions as described in the Annual Plan.

(g) For an individual who is enrolled in a residential program the monitoring of services may be combined with the site visits described in section (3) 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 must occur, using questions established by the Department. The services coordinator must determine whether financial records, bank statements, and personal spending funds are correctly reconciled and accounted for.

(i) The financial review standards for 24-hour residential programs are described in OAR 411-325-0380.

(ii) The financial review standards for adult foster homes 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.

(h) If state plan personal care services as described in OAR 411-034-0070 are authorized in an Annual Plan, the services must be monitored as described in OAR 411-034-0070.

(3) SITE VISITS.

(a) The CDDP must ensure that quarterly site visits are conducted at each child or adult foster home and each 24-hour residential program setting licensed by the Department to serve individuals with intellectual or developmental disabilities.

(b) The CDDP must establish an annual schedule for site visits to each site that is owned, operated or controlled by:

(A) An employment program certified and endorsed under OAR chapter 411, division 345; and

(B) A community living supports program certified and endorsed under OAR chapter 411, division 450.

(c) The CDDP must conduct at least one visit annually to the home of an individual receiving services in a supported living setting.

(d) The CME must conduct at least one visit annually to the home of an individual receiving services in the home.

(e) Site visits may be increased for any of the following reasons including, but not limited to:

(A) Increased certified and licensed capacity;

(B) New individuals receiving services;

(C) Newly licensed or certified and endorsed provider;

(D) An abuse investigation;

(E) A serious event;

(F) A change in the management or staff of the licensed site or certified and endorsed program operator;

(G) An ISP team request; or

(H) Significant change in the functioning of an individual who receives services at the site.

(f) The CME must develop a procedure for the conduct of the site visits.

(g) The CME must document site visits and provide information concerning the site visits to the Department upon request.

(h) If there are no Department-funded individuals at the site, a visit by the CME is not required.

(i) When a provider is a Department-contracted and licensed, certified, and endorsed 24-hour residential program for children and the children's residential services coordinator for the Department is assigned to monitor services, the children's residential services coordinator and the CDDP shall coordinate the site visit. If the site visit is made by Department staff, Department staff shall provide the results of the site visit to the local services coordinator.

(j) The Department may conduct site visits on a more frequent basis than described in this section based on program needs.

(4) MONITORING FOLLOW-UP. A case manager and the CME are responsible for ensuring the appropriate follow-up to monitoring of services, except in the instance of children in 24-hour residential programs directly contracted with the Department when the Department conducts the follow-up.

(a) If the case manager determines that developmental disabilities services are not being delivered as agreed in the ISP for an individual, or that the service needs of an individual have changed since the last review, the case manager must initiate at least one of the following actions:

(A) Update the ISP of the individual.

(B) To remediate service delivery shortcomings, provide or refer technical assistance to an agency provider or common law employer for a personal support worker.

(b) If there are concerns regarding the ability of a provider to provide services, the CME must determine the need for technical assistance or other follow-up activities, such as coordination or provision of technical assistance, referral to the CDDP manager or brokerage director for consultation or corrective action, requesting assistance from the Department for licensing or other administrative support, or meeting with the executive director or board of directors of the provider.

(5) DEPARTMENT NOTIFICATION. The CME must notify the Department when:

(a) A provider demonstrates substantial failure to comply with any applicable licensing, certification, or endorsement rules for Department-funded programs.

(b) A personal support worker may have met any of the conditions identified in OAR 411-375-0070 that would cause the Department to inactivate or terminate the provider enrollment of the worker.

(c) The CME 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.

(d) Any individual receiving Department-funded developmental disabilities services dies. Notification must be made within one business day of the death. Entry must be made into the Serious Event Review System according to Department guidelines.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
Hist.: APD 28-2016, f. & cert. ef. 6-29-16

411-415-0100
Specialized Services in a Nursing Facility

An individual residing in a nursing facility determined to require specialized services, as described in OAR 411-070-0043, must have an annual plan for specialized services incorporated with a plan of care by the nursing facility.

(1) A case manager must coordinate with the individual, the legal representative of the individual, the staff of the nursing facility, and other service providers, as appropriate, to provide or arrange the specialized services. The plan for specialized services must include:

(a) The name of the service provider.

(b) A description of the specialized services to be provided.

(c) The number of hours of service per month.

(d) A description of how the services must be tracked.

(e) A description of the process of communication between the specialized service provider and the nursing facility in the event of unusual incidents, illness, absence, and emergencies.

(2) A case manager must complete an annual review of the plan for specialized services or when there has been a significant change in the level of functioning of the individual.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
Hist.: APD 28-2016, f. & cert. ef. 6-29-16

411-415-0110
Records Requirements

(1) In order to meet Department and federal record documentation requirements, the CME through the employees of the CME, must maintain a service record for each individual who receives services from the CME. The service record must include:

(a) Documentation of the functional needs assessment defining the support needs for ADL, IADL, and other health-related tasks.

(b) Documentation of choice advising.

(c) Documentation that the individual is eligible for any service authorized in an ISP.

(d) Referral information or documentation of referral materials sent to a provider or another CME.

(e) Progress notes written by a case manager as described in section (2) of this rule.

(f) The findings from service monitoring.

(g) Medical information, as appropriate.

(h) Entry and exit meeting documentation related to residential programs, including plans developed as a result of the meeting.

(i) Current and previous ISP or Annual Plan, including support documents and documentation that the plan is authorized by a case manager.

(j) A Nursing Service Plan must be present when Department funds are used to purchase services requiring the education and training of a licensed professional nurse.

(k) Copies of any incident reports initiated by a CME representative for any unusual incident that occurred at the CME or in the presence of the CME representative.

(l) Documentation of a review of unusual incidents received from providers. Documentation of the review of unusual incidents must be made in progress notes and a copy of the incident report must be maintained by the CME.

(m) Documentation of Medicaid eligibility, if applicable.

(n) The initial and annual level of care determination on a form prescribed by the Department.

(A) For individuals receiving CIIS or services in a 24-hour residential program for children, the CDDP must maintain a current copy of the annual level of care determination or reflect documentation of attempts to obtain a current copy.

(B) Once an individual is enrolled in a Brokerage, the CDDP must maintain a copy of the initial level of care determination form completed by the CDDP.

(o) Legal records, such as guardianship papers, civil commitment records, court orders, and probation and parole information (as appropriate).

(p) A case manager must maintain documentation of the referral process of an individual to a provider and if applicable, include the reason the provider preferred by the individual declined to deliver services to the individual.

(q) An information sheet or reasonable alternative must be kept current and reviewed at least annually for each individual receiving case management services. Information must include:

(A) The name of the individual, current address, date of entry into the CME, date of birth, gender, 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 name, address, and telephone number of:

(i) For an adult, the legal or designated representative, family, and other significant person of the individual (as applicable), and for a child, the parent or guardian and education surrogate (if applicable);

(ii) The primary care provider and clinic preferred by the individual;

(iii) The dentist preferred by the individual;

(iv) The school, day program, or employer of the individual (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.

(2) PROGRESS NOTES. Progress notes must include documentation of the delivery of case management services provided to an individual by a case manager. Progress notes must be recorded chronologically in the order they are made and documented consistent with CME policies and procedures. All late entries must be appropriately noted as such. At a minimum, progress notes must 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 services were rendered;

(b) The name of the individual receiving service;

(c) The name of the CME, the person providing the services (i.e., the signature and title of the case manager), and the date the entry was recorded and signed;

(d) The nature and content of the case management services delivered and whether goals specified in the service plan have been achieved;

(e) Place of service. Place of service means the county where the CME or agency providing case management services is located, including the main address. The place of service may be a standard heading on each page of the progress notes; and

(f) For notes pertaining to meetings with or discussions about the individual, the names of other participants, including the titles and agency representation of the participants, if any.

(3) For individuals living in their own or family home, the CME must maintain a minimum acceptable record of expenditures for at least three years that includes:

(a) Itemized invoices and receipts to record the purchase of any single item.

(b) A trip log indicating purpose, date, and total miles to verify vehicle mileage reimbursement.

(c) Pay records to record employee services, including timesheets signed by both employee and employer.

(d) Itemized invoices for any services purchased from independent contractors, provider agencies, and professionals. Itemized invoices must include:

(A) The name of the individual to whom services were provided;

(B) The date of the services;

(C) The amount of services; and

(D) A description of the services.

(e) Evidence confirming the receipt, and securing the use of, assistive devices, environmental safety modifications, and environmental modifications.

(A) When an assistive device is obtained for the exclusive use of an individual, the CME must record the purpose, final cost, and date of receipt.

(B) The CME must secure use of equipment or furnishings costing more than $500 through a written agreement between the CME and the individual or the legal representative of the individual that specifies the time period the item is to be available to the individual and the responsibilities of all parties if the item is lost, damaged, or sold within that time period.

(4) Verification that providers meet the requirements to deliver services they are authorized to deliver including:

(a) Verification of a valid license to drive for any personal support worker, and proof of current auto insurance for the vehicle used for transportation, upon authorization of community transportation services.

(b) Documentation supporting the rate paid to a provider when it is above the minimum described in rule, policy, In-Home Expenditure Guidelines, or the base rate for a personal support worker identified in the current Collective Bargaining Agreement, including support for an enhanced and an exceptional personal support worker rate.

(5) Failure to furnish written documentation upon the 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.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
Hist.: APD 28-2016, f. & cert. ef. 6-29-16

411-415-0120
Reimbursement for Case Management Services

A CME is reimbursed for case management activities. Reimbursement may only be made when:

(1) The claim for reimbursement is for a service provided to an individual determined eligible for case management services.

(2) The individual providing the service is a qualified case manager as described in OAR 411-415-0040.

(3) An individual is properly enrolled into the Department's payment system.

(4) A claim has been made in the Department's payment system.

(5) Case management has been authorized on an ISP or as part of an Annual Plan.

(6) The claim is for a qualifying case management service.

(7) A progress note is in the individual file supporting the delivery of a case management service.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695
Hist.: APD 28-2016, f. & cert. ef. 6-29-16

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Rule Caption: ODDS: Independent Providers Delivering Developmental Disabilities Services
Adm. Order No.: APD 29-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 5-1-2016
Rules Adopted: 411-375-0035, 411-375-0055
Rules Amended: 411-375-0000, 411-375-0010, 411-375-0020, 411-375-0040, 411-375-0050, 411-375-0070, 411-375-0080
Rules Repealed: 411-375-0030
Rules Ren. & Amend: 411-375-0060 to 411-375-0045
Subject: The Department of Human Services, Office of Developmental Disabilities Services (Department) is permanently updating the rules for independent providers delivering developmental disabilities services in OAR chapter 411, division 375.

The rules in OAR chapter 411, division 375 are being amended to:

- Make permanent temporary changes that became effective on January 1, 2016;

- Provide consistency across services by removing terms included in the general definitions rule, OAR 411-317-0000;

- Implement changes associated with the Fair Labor Standards Act and Collective Bargaining Agreement regarding hours, pay, and benefits for personal support workers;

- Implement changes to the termination and inactivation procedures;

- Expand OAR chapter 411, division 375 to include standards and requirements related to independent providers that are not personal support workers, as well as pulling the standards for employers from other rules and incorporating them into OAR chapter 411, division 375; and

- Provide standards for documentation for independent providers.

Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-375-0000
Purpose

(1) The rules in OAR chapter 411, division 375 establish the standards and procedures governing independent providers and the fiscal services provided on behalf of individuals who employ or contract with an independent provider.

(2) Independent providers provide home and community-based waiver, state plan, and general fund services to individuals eligible for developmental disabilities services and receiving supports authorized by a case management entity.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-619, 427.007
Hist.: APD 30-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 48-2014, f. 12-26-14, cert. ef. 12-28-14; APD 29-2016, f. & cert. ef. 6-29-16

411-375-0010
Definitions and Acronyms

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 375.

(1) "Active Provider Number" means an identifying number that is issued by the Department to an independent provider after the independent provider completes the qualification and enrollment conditions as described in OAR 411-375-0020. An active provider number is a provider number that is not currently in inactivated or terminated status.

(2) "ADL" means "activities of daily living".

(3) "Base Pay Rate" means the hourly wage to be paid to personal support workers, without any differentials, established in the Collective Bargaining Agreement.

(4) "Behaviorally-Driven Services and Supports" means the behavioral treatments identified in a functional needs assessment that an individual requires in addition to routine assessed ADL and IADL supports.

(5) "Burden of Proof" means that the existence or nonexistence of a fact is established by a preponderance of the evidence.

(6) "CDDP" means "Community Developmental Disability Program".

(7) "CIIS" means "Children's Intensive In-Home Services".

(8) "Collective Bargaining Agreement" means the Collective Bargaining Agreement between the Home Care Commission and the Service Employees International Union, Local 503, Oregon Public Employees Union regarding wages, hours, rules, and working conditions.

(9) "Common Law Employer" means a person responsible for the management of personal support workers in their duties described in these rules. Common law employers are also known as as an employer of record (EOR).

(10) "Common Law Employer Proxy" means a person who is delegated specific tasks to assist a common law employer in the duties of a common law employer.

(11) "Community Transportation" means the ancillary service described in OAR 411-435-0050 that enables an individual to gain access to community-based state plan and waiver services, activities and resources that are not medical in nature. Community transportation is provided in the area surrounding the home of the individual that is commonly used by people in the same area to obtain ordinary goods and services. Community transportation is available through the Community First Choice State Plan Amendment.

(12) "Confidentiality" means the conditions for use and disclosure of specific information governed by other laws and rules including, but not limited to, OAR 407-014-0000 to 407-014-0070 (Privacy of Protected Information).

(13) "Department Funds" means state public funds or Medicaid funds used to purchase developmental disabilities services for individuals enrolled in services as defined in this rule.

(14) "Enhanced Personal Support Worker" means a personal support worker who is certified by the Home Care Commission to provide services for individuals who require advanced medically or behaviorally-driven services and supports as defined and assessed through a functional needs assessment tool.

(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) "Exceptional Personal Support Worker" means a personal support worker who is certified by the Home Care Commission to provide services for individuals who require extensive medically or behaviorally-driven services and supports as assessed by a functional needs assessment tool and whose service needs also require staff to be awake more than 20 hours in a 24-hour period.

(17) "eXPRS" means "Express Payment and Reporting System". eXPRS is the Department's information system that tracks and documents service delivery of claims funded by the Department.

(18) "Failure to Act as a Mandatory Reporter" means that a personal support worker has reasonable cause to believe that the abuse of a child, an older adult, adult with an intellectual or developmental disability or mental illness, or a resident of a nursing facility has occurred, but fails to report the suspected abuse as required by ORS 419B.015, 124.065, 430.743, or 441.645.

(19) "Failure to Provide Services as Required" means an independent provider does not provide services to an individual as described in the service agreement.

(20) "FICA" means "Federal Insurance Contributions Act".

(21) "Fiscal Improprieties" means financial misconduct involving the money, property, or benefits of an individual.

(a) Fiscal improprieties include, but are not limited to, financial exploitation, borrowing money from an individual, taking property or money from an individual, having an individual purchase items for the independent provider, forging the signature of an individual, falsifying payment records, claiming payment for hours not worked, repeatedly claiming payment for hours not prior authorized, or similar acts intentionally committed for financial gain.

(b) Fiscal improprieties do not include the exchange of money, gifts, or property between a personal support worker and an individual with whom the personal support worker is 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.

(22) "Fiscal Intermediary" means a person or entity that receives and distributes Department funds on behalf of an individual who employs or contracts with a personal support worker to provide services.

(23) "IADL" means "instrumental activities of daily living".

(24) "Imminent Danger" means there is reasonable cause to believe the life or physical, emotional, or financial well-being of an individual is in danger if no intervention is immediately initiated.

(25) "Inactivation" means an independent provider has a Department issued provider number that has been inactivated in accordance with OAR 411-375-0070(1) or 411-375-0070(2).

(26) "Independent Provider" means a personal support worker, a person who is paid as a contractor, or a self-employed person. An agency or the employee of an agency is not an independent provider.

(27) "ISP" means "Individual Support Plan".

(28) "Lack of Skills, Knowledge, or Ability to Adequately or Safely Provide Services" means anan independent provider does not possess the skills to perform services as defined in this rule. The independent provider is not physically, mentally, or emotionally capable of providing services and the lack of skills puts an individual at risk because the independent provider fails to perform, or learn to perform, the duties needed to adequately meet the needs of the individual.

(29) "Medically-Driven Services and Supports" means the medical treatments identified in a functional needs assessment that an individual requires in addition to routine assessed ADL and IADL supports.

(30) "Office of Administrative Hearings" means the office described in ORS 183.605 established within the Employment Department to conduct contested case proceedings on behalf of designated state agencies.

(31) "Personal Support Worker":

(a) Means a person:

(A) Who has a Medicaid provider number;

(B) Hired by an individual with an intellectual or developmental disability or the representative of the individual;

(C) Who receives money from the Department for the purpose of providing services to an individual in the home or community of the individual; and

(D) Whose compensation for providing services is provided in whole or in part through a case management entity.

(b) This definition of personal support worker is intended to be interpreted consistently with ORS 410.600.

(32) "Preponderance of the Evidence" means that one party's evidence is more convincing than the other party's evidence in a contested case hearing.

(33) "Protective Service and Abuse Rules" mean the rules described in OAR chapter 411, division 020, OAR chapter 407, division 045, OAR chapter 413, division 015, and OAR chapter 943, division 045.

(34) "Provider Enrollment" means the process for enrolling an independent provider for the purpose of receiving payment for authorized services provided to an individual. Provider enrollment includes the completion and submission of a Provider Enrollment Agreement before receiving a provider number.

(35) "Provider Number" means the identifying number issued to a qualified independent provider.

(36) "Restricted Personal Support Worker" means the Department or the designee of the Department has placed restrictions on the provider enrollment of a personal support worker as described in OAR 411-375-0020.

(37) "Termination" means an independent provider has a Department issued provider number that has been terminated in accordance with OAR 411-375-0070(3).

(38) "Travel Directly" means that a personal support worker's travel from one individual's home or service setting to another individual's home or service setting is not interrupted for reasons other than to eat a meal, purchase fuel for the vehicle being used for the travel, use a restroom, or change buses, trains, or other modes of public transit.

(39) "These Rules" mean the rules in OAR chapter 411, division 375.

(40) "Unacceptable Conduct at Work" means an indpependent provider 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 an individual that is either unsatisfactory to the individual or neglects the individual's service needs; or

(b) Inviting unwelcome guests or pets into an individual's home, resulting in the individual's dissatisfaction or a personal support worker's inattention to the individual's required service needs.

(41) "Violation of a Drug-Free Workplace" means there was a credible complaint against an independent provider for:

(a) Being intoxicated by alcohol, inhalants, prescription drugs, or other drugs, including over-the-counter medications, while:

(A) Responsible for the care of an individual;

(B) In the individual's home; or

(C) Transporting the individual.

(b) Manufacturing, possessing, selling, offering to sell, trading, or using illegal drugs while providing authorized services to an individual or while in the indivdiual's home.

(42) "Violation of Protective Service and Abuse Rules" means, based on a substantiated allegation of abuse, an independent provider was found to have violated the protective service and abuse rules described in OAR chapter 411, division 020, OAR chapter 407, division 045, OAR chapter 413, division 015, or OAR chapter 943, division 045.

(43) "Workday" means 12:00 AM through 11:59 PM.

(44) "Work Week" means 12:00 AM Sunday through 11:59 PM Saturday.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-619, 427.007
Hist.: APD 30-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 48-2014, f. 12-26-14, cert. ef. 12-28-14; APD 29-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 29-2016, f. & cert. ef. 6-29-16

411-375-0020
Independent Provider Enrollment and Qualifications

(1) INDEPENDENT PROVIDER QUALIFICATIONS: An independent provider who is qualified to provide services must:

(a) Be at least 18 years of age.

(b) Have approval to work based on a background check completed by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (3) of this rule.

(c) Not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275 unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent provider was hired or contracted.

(d) Be free of convictions, founded allegations of abuse, or substantiated allegations of abuse by the appropriate agency including, but not limited to, the Department or case management entity.

(e) Be legally eligible to work in the United States.

(f) Demonstrate by background, education, references, skills, and abilities that the independent provider is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by the individual, or their legal or designated representative including:

(A) Ability and sufficient education to follow oral and written instructions and keep any required records;

(B) Possess the physical health, mental health, good judgment, and good personal character determined necessary to provide services;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the independent provider has knowledge of emergency procedures specific to the individual.

(g) Maintain confidentiality and safeguard individual information. Unless given specific permission by an individual or the legal representative of an individual, the independent provider may not share any personal information about the individual including medical, social service, financial, public assistance, legal, or other personal details.

(h) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/).

(i) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department.

(j) Have a tax identification number or Social Security number that matches the legal name of the independent provider as verified by the Internal Revenue Service or Social Security Administration.

(k) If providing services requiring professional licensure, possess a current and unencumbered license. The individual the designated or legal representative of the individual, or the case management entity must check the license status to verify the license is current and unencumbered.

(l) If transporting an individual, have a valid license to drive and proof of insurance, as well as any other license or certification that may be required under state and local law depending on the nature and scope of the transportation. Copies of these documents must be available to any case management entity that authorizes community transportation upon authorization and as requested.

(m) An independent provider must meet the qualifications for a provider as described in the Oregon Administrative Rules that are relevant to the specific service when applicable.

(2) INDEPENDENT PROVIDER EXCLUSIONS. An independent provider may not be authorized to provide services to an individual if:

(a) The independent provider is the parent of the individual if the individual is less than 18 years of age;

(b) The independent provider is the legal representative of the individual who has not appointed a designated representative to plan supports for the individual;

(c) The independent provider is the designated representative of the individual;

(d) The independent provider is the spouse of the individual; or

(e) The independent provider is the common law employer or commom law employer proxy for the individual.

(3) BACKGROUND CHECKS.

(a) A subject individual as defined in OAR 407-007-0210 may be approved for one position to work statewide when the subject individual is working in the same employment role with the same population. The Background Check Request Form must be completed by the subject individual to show intent to work statewide.

(b) When an independent provider is approved without restrictions following a background check fitness determination, the approval must meet the provider enrollment requirements for the employment role of the independent provider.

(c) If an independent provider has been approved under OAR 407-007-0200 to 407-007-0370 on a background check submitted to the Department between July 1, 2012 and June 30, 2014, the independent provider may use that approval notice to work statewide with the same population until a new background check is needed. Statewide clearance does not apply to a restricted personal support worker.

(d) Background check approval is effective for two years from the date of fitness determination to provide services except in the following circumstances:

(A) A new fitness determination is conducted resulting in a change in approval status; or

(B) The Department has terminated the provider enrollment for the independent provider.

(e) The case management entity may conduct a background recheck more frequently based on:

(A) Additional information discovered about the independent provider, such as possible criminal activity or other allegations; or

(B) At the request of the individual or designated common law employer. Upon request, the personal support worker must provide any additional info to complete the updated background recheck within 30 days.

(f) An independent provider must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and 407-007-0290 to the case management entity within 24 hours.

(4) The Department may not complete provider enrollment in the following circumstances:

(a) The applicant has been suspended or terminated as a provider by another division within the Department or the Oregon Health Authority;

(b) The applicant has a history of violating protective service and abuse rules or has a founded report of child abuse or substantiated adult abuse;

(c) The applicant has committed fiscal improprieties;

(d) The applicant has demonstrated a lack of skills, knowledge, or ability to adequately or safely provide services;

(e) The applicant has an unacceptable background check or the background check results in a closed case pursuant to OAR 407-007-0325;

(f) The applicant is on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/);

(g) The case management entity has documentation the applicant is not capable of performing required services in a professionally competent, safe, legal, or ethical manner; or

(h) The tax identification number or Social Security number for the applicant does not match the legal name of the applicant as verified by the Internal Revenue Service or Social Security Administration.

(5) A personal support worker must attend a personal support worker orientation consistent with the Collective Bargaining Agreement.

(6) RESTRICTED PERSONAL SUPPORT WORKER PROVIDER ENROLLMENT.

(a) The Department may enroll an applicant as a restricted personal support worker. A restricted personal support worker may only provide services to a specific individual who is a family member, neighbor, or friend.

(A) After conducting a weighing test as described in OAR 407-007-0200 to 407-007-0370, the Department may approve a restricted enrollment for an applicant with a prior criminal record, unless under OAR 407-007-0275 the applicant has been found ineligible due to ORS 443.004.

(B) The Department may approve a restricted enrollment for an applicant based on the lack of skills, knowledge, or ability of the applicant to adequately or safely provide services.

(b) To remove restricted personal support worker status, the applicant must complete a new application and background check and be approved by the Department.

(7) ENHANCED AND EXCEPTIONAL PERSONAL SUPPORT WORKERS.

(a) ENHANCED PERSONAL SUPPORT WORKERS.

(A) A personal support worker must be certified by the Home Care Commission as an enhanced personal support worker to provide services for individuals who require advanced medically or behaviorally-driven services and supports as assessed by a functional needs assessment.

(B) Enhanced personal support workers are paid for providing ADL and IADL services at the enhanced personal support worker rate set forth in the Collective Bargaining Agreement.The enhanced personal support worker rate is effective the first day of the month following the month in which both:

(i) The personal support worker is certified by the Oregon Home Care Commission to provide services; and

(ii) The outcome of the individual's functional needs assessment indicates the need for assistance with advanced medically or behaviorally-driven services.

(b) EXCEPTIONAL PERSONAL SUPPORT WORKER.

(A) A personal support worker must be certified by the Home Care Commission as an exceptional personal support worker to provide services for individuals who require assistance with extensive medically or behaviorally-driven services and supports as assessed by a functional needs assessment.

(B) Exceptional personal support workers are paid for providing ADL and IADL services at the exceptional personal support worker rate set forth in the Collective Bargaining Agreement.The exceptional personal support worker rate is effective the first day of the month following the month in which both:

(i) The personal support worker is certified by the Oregon Home Care Commission to provide services; and

(ii) The outcome of the individual's functional needs assessment indicates the need for assistance with extensive medically or behaviorally-driven services and at least 20 hours per day of attendant care support excluding 2:1 support hours.

(c) A personal support worker who has been certified by the Oregon Home Care Commission to provide enhanced or exceptional supports may not receive the enhanced or exceptional rate when providing services to an individual whose functional needs assessment does not indicate the need for assistance with advanced or extensive medically or behaviorally-driven services except as required by the Collective Bargaining Agreement.

(8) INDEPENDENT PROVIDER CONTINUED ENROLLMENT RESPONSIBILITIES.

(a) An independent provider is responsible for maintaining an active provider number by:

(A) Completing and submitting a new Provider Enrollment Agreement to the Department at least 55 calendar days prior to the end date of the agreement; and

(B) Completing and submitting a Background Check Request Form and receiving approval to work by the Department at least 55 calendar days prior to the end of the background check approval period.

(b) An independent provider is responsible to attend trainings and maintain certifications as required by applicable program rules.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-619, 427.007
Hist.: APD 30-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 48-2014, f. 12-26-14, cert. ef. 12-28-14; APD 29-2016, f. & cert. ef. 6-29-16; APD 29-2016, f. & cert. ef. 6-29-16

411-375-0035
Documentation and Reporting Requirements

(1) SERVICE AGREEMENT.

(a) An independent provider may not provide services to an individual without a completed and authorized Service Agreement.

(b) An independent provider must maintain a copy of the authorized Service Agreement for the authorized service period.

(c) For personal support workers, the Service Agreement serves as a job description.

(d) For independent providers who are not personal support workers, the independent provider's signature on the individual's ISP may serve as the Service Agreement.

(2) PROGRESS NOTES.

(a) Independent providers must maintain regular progress notes. The progress note must include, at minimum, the following information regarding the service rendered:

(A) Date and time the service was provided; and

(B) Information regarding progress towards achieving the intended ISP goal identified in the Service Agreement for which the service was delivered.

(b) For a personal support worker, progress notes must be submitted to the case management entity upon request from the case management entity and with a timesheet as part of the claim for payment.

(c) For an independent provider who is not a personal supportworker, progress notes must be submitted as required by applicable program rules.

(3) INCIDENT REPORTING.

(a) Independent providers must notify the individual's case management entity of any injury, accident, act of physical aggression, or unusual incident involving an individual.

(b) Independent providers must notify the individual's case management entity of any reasonable suspicion that an individual is the victim of abuse.

(c) Independent providers who are mandatory reporters must also make reports of suspected abuse consistent with ORS 419B.015, 124.065, 430.743, or 441.645.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007
Hist.: APD 29-2016, f. & cert. ef. 6-29-16

411-375-0040
Fiscal and Accountability Responsibility

(1) DIRECT SERVICE PAYMENTS. The case management entity or contracted fiscal intermediary makes payment to an independent provider on behalf of an individual for all services.

(a) Payment is considered full payment for the services rendered. The independent provider may not, under any circumstances, demand or receive additional payment for Department-funded services from the individual or any other source.

(b) The Department only makes payment for services that:

(A) Are authorized in an ISP, and included in a Service Agreement;

(B) The provider has been authorized in eXPRS to deliver the service; and

(C) The provider has delivered the service.

(c) The Department does not make Department funds available to an individual or common law employer to pay an independent provider.

(d) The Department only makes payment to an enrolled provider who actually performs the authorized services. Federal regulations prohibit the Department from making payment to a collection agency.

(e) All Department funds paid to a personal support worker must come through a fiscal intermediary.

(2) TIMELY SUBMISSION OF CLAIMS. In accordance with 42 CFR 447.45, all claims for services must be submitted within 12 months from the date of services in order to be considered for payment. A claim submitted after 12 months from the date of services may not be considered for payment.

(3) CLAIM OR ENCOUNTER SUBMISSION.

(a) Submission of a claim, encounter, or other payment request document constitutes the agreement of an independent provider that:

(A) The services were provided in compliance with the Service Agreement in effect on the date of service;

(B) The information on the claim, encounter, or other payment request document, regardless of the format, is true, accurate, and complete; and

(C) The independent provider understands that payment of the claim, encounter, or other payment request document is from Department funds and that any falsification or concealment of a material fact may result in prosecution under federal and state laws.

(b) The independent provider must submit a claim for payment directly into eXPRS, unless an exception has been granted by the case management entity.

(A) Claims for payment submitted by independent providers who are not personal support workers must include documentation from the provider of services delivered.

(B) Claims for payment submitted by personal support workers must meet the requirements of a properly completed timesheet as defined by the Collective Bargaining Agreement including submission of progress notes as required by this rule.

(4) CLAIM OR ENCOUNTER AUTHORIZATION. Authorization of a submitted claim, encounter, or other payment request document by the employer, constitutes agreement that the independent provider provided services in accordance with the claim.

(5) INDEPENDENT PROVIDER PAYMENT LIMITATIONS.

(a) Department funds may not pay for services delivered by an independent provider who does not possess an active provider number issued by the Department on the date services are delivered.

(b) An active provider number with the Department is not a guarantee that an independent provider shall receive any minimum amount of work or payment from the case management entity.

(c) Payment is not made for services delivered to any individual prior to:

(A) The return of a signed Service Agreement, specific to the individual, to the case manager of the individual.

(i) When the provider is a personal support worker, a completed Service Agreement must include a dated signature from the common law employer and the personal support worker.

(ii) When the provider is an independent provider, but not a personal support worker, a completed Service Agreement must include the name and dated signature of the individual or the representative of the individual.

(B) Authorization of the services in eXPRS.

(d) A personal support worker may not work more than 50 hours in a work week, per individual, unless:

(A) The personal support worker is delivering daily relief care; or

(B) An exception has been granted by the case management entity. All determinations regarding exceptions to the 50 hour limitation are final.

(e) A personal support worker may not work more than 40 hours in a work week for any one child in a CIIS program.

(6) ANCILLARY CONTRIBUTIONS FOR PERSONAL SUPPORT WORKERS.

(a) FICA. Acting on behalf of the individual, the case management entity or contracted fiscal intermediary shall apply any applicable FICA regulations including:

(A) Withholding the FICA contribution of the personal support worker from the payment to the personal support worker; and

(B) Submitting the FICA contribution of the individual and the amounts withheld from the payment to the personal support worker to the Social Security Administration.

(b) BENEFIT FUND ASSESSMENT. The Workers' Benefit Fund pays for programs that provide direct benefits to an injured worker and the beneficiary of the injured worker and also assists an employer in helping an injured worker return to work. The Department of Consumer and Business Services sets the Workers' Benefit Fund assessment rate for each calendar year. The case management entity or contracted fiscal intermediary 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 individual, the case management entity or contracted fiscal intermediary:

(A) Deducts the share of the Benefit Fund assessment rate for the personal support worker for each hour or partial hour worked;

(B) Collects the share of the Benefit Fund assessment rate for the individual for each hour or partial hour of paid services received; and

(C) Submits the contributions of the personal support worker and the individual to the Workers' Benefit Fund.

(c) The case management entity or contracted fiscal intermediary submits the unemployment tax.

(7) STATE AND FEDERAL INCOME TAX WITHHOLDING.

(a) The case management entity or contracted fiscal intermediary withholds state and federal income taxes on all payments to personal support workers as indicated in the Collective Bargaining Agreement.

(b) Personal support workers must complete and return a current Internal Revenue Service (IRS) W-4 form.

(A) Personal support workers working with individuals receiving services through a CDDP or Support Services Brokerage must return all applicable IRS forms to the local office of the CDDP or Support Services Brokerage.

(B) Personal support workers working with individuals receiving services through CIIS must return the IRS forms to the Central Office of the Department.

(C) The case management entity or contracted fiscal intermediary must apply standard income tax withholding practices in accordance with 26 CFR 31.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-619, 427.007
Hist.: APD 30-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 48-2014, f. 12-26-14, cert. ef. 12-28-14; APD 29-2016, f. & cert. ef. 6-29-16

411-375-0045
Overpayments

(1) An overpayment is any payment made by the Department or case management entity to an independent provider that is more than the independent provider is permitted to receive under DHS rules. An independent provider may only receive payment for a number of hours that are actually provided and do not exceed the amount stated in a Service Agreement.

(2) Overpayments are categorized as follows:

(a) ADMINISTRATIVE ERROR. The case management entity failed to authorize, compute, or process the correct amount of service hours or wage rate.

(b) INDEPENDENT PROVIDER ERROR. The Department overpays the independent provider due to a misunderstanding or unintentional error.

(c) FRAUD. "Fraud" means taking actions that may result in the independent provider 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 independent provider was not entitled to and any act that constitutes fraud under applicable federal or state law (including 42 CFR 455.2). The Department of Justice, Medicaid Fraud Unit determines when a Medicaid fraud allegation is pursued for prosecution.

(3) The Department may recover an overpayment established by a judgment in a state or federal court, by the Department or another administrative agency in a contested case proceeding, or by a signed document in which the person acknowledges the overpayment and waives the right to a contested case hearing.

(4) Overpayments for personal support workers are recovered as follows:

(a) Overpayments are collected prior to garnishments, such as child support, Internal Revenue Service back taxes, or educational loans.

(b) Overpayments due to administrative error or personal support worker error are recouped at no more than five percent of the total for the hours paid until repaid in full.

(c) When a fraud overpayment has occurred, the Department shall determine the manner and the amount to be recovered.

(d) When a provider is no longer employed as a personal support worker, any remaining overpayment is deducted from the final check to the

provider. The provider is responsible for repaying the amount in full when the final check is insufficient to cover the remaining overpayment.

(3) Overpayments for independent providers who are not personal support workers are recovered as described in OAR chapter 407, division 120.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-619, 427.007
Hist.: APD 30-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 48-2014, f. 12-26-14, cert. ef. 12-28-14; Renumbered from 411-375-0060 by APD 29-2016, f. & cert. ef. 6-29-16

411-375-0050
Personal Support Worker Benefits and Secondary Expenses

(1) The only benefits available to personal support workers are negotiated in the Collective Bargaining Agreement and provided in Oregon Revised Statute. The Collective Bargaining Agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Personal support workers are not employees of a case management entity.

(2) Workers' compensation, as defined in Oregon Revised Statute, is available to eligible personal support workers as described in the Collective Bargaining Agreement. In order to receive services provided by a personal support worker, an individual, the designated common law employer or the common law employer proxy must provide written authorization and consent to the Department for the provision of workers' compensation insurance for the personal support worker.

(3) COMMUNITY TRANSPORTATION.

(a) A personal support worker may be reimbursed for providing community transportation related to services if the community transportation is prior authorized by a case manager and reflected in the ISP for an individual in accordance with OAR 411-435-0050. A personal support worker providing community transportation must have a valid license to drive, a good driving record, and proof of insurance for the vehicle used to transport the individual, as well as any other license or certificate that may be required under state and local law depending on the nature and scope of the transportation.

(b) Community transportation services exclude medical transportation. Medical transportation is provided through Medical Assistance Programs (MAP).

(c) The Department is not responsible for vehicle damage or personal injury sustained while using a personal motor vehicle for ISP-related transportation except as may be covered by workers' compensation.

(d) Reimbursement for transporting an individual to accomplish ADL, IADL, or a health-related task within the community in which the individual lives or an employment goal identified on an ISP is on a per-mile basis as outlined in the Collective Bargaining Agreement.

(4) TRAVEL BETWEEN WORKSITES. A personal support worker who travels directly between the home or service setting of one individual and the home or service setting of another individual is paid at the base pay rate, as defined in the Collective Bargaining Agreement, for the time spent traveling directly between the homes or service settings.

(a) Unless otherwise specified in statute or rule the amount of time a personal support worker may take to travel directly travel from one individual's home or service setting to another individual's home or service setting may not exceed one hour.

(b) The total time spent traveling directly between the homes or service settings of all individuals a personal support worker is authorized to deliver services to may not total more than ten percent of the total wages that the personal support worker claims during a pay period as described in the Collective Bargaining Agreement.

(c) When a personal support worker uses the personal support worker's own vehicle to travel directly between the homes or service settings of two individuals, the Department shall determine the time needed for a personal support worker to travel directly between the homes or service settings of the two individuals based on a time estimate published in a common, publicly-available, web-based mapping program.

(d) When a personal support worker uses public transportation to travel directly between the homes or service settings of two individuals, payment for travel time is based on the public transportation providers' scheduled pick-up and drop-off times for the stops nearest the individuals' homes or service settings.

(e) When a personal support worker uses non-motorized transportation to travel directly between the homes or service settings of two individuals, payment for travel time shall be based on a time estimate published in a common, publicly-available web-based mapping program.

(5) Claims for travel time exceeding the Department's time estimates for the travel time require a written explanation from the personal support worker. Time claimed in excess of the Department's time estimate may not be paid.

(6) Under no circumstances may a personal support worker be paid for time spent in transit to or from the personal support worker's own residence.

(7) Personal support workers receive mileage reimbursement only as set forth in section (3) of this rule.

(8) GLOVES AND MASKS. Once all public and private resources have been exhausted, an emergency supply of protective gloves and masks must be made available to a personal support worker for the safety of the personal support worker in response to documented changing or newly identified individual need as outlined in the Collective Bargaining Agreement.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-619, 427.007
Hist.: APD 30-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 48-2014, f. 12-26-14, cert. ef. 12-28-14; APD 29-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 29-2016, f. & cert. ef. 6-29-16

411-375-0055
Standards for Common Law Employers for Personal Support Workers

(1) COMMON LAW EMPLOYER. A common law employer is required when a personal support worker is selected by an individual to deliver supports. Neither the Department, certified and endorsed or licensed provider agencies, nor case management entities may act as the common law employer for a personal support worker.

(2) The relationship between a personal support worker and an individual, or the designated common law employer of the individual, is an employee and employer relationship.

(3) The individual or their legal or designated representative has the right to choose any personal support worker enrolled as a provider as described in OAR 411-375-0020 who meets the specific program qualifications.

(4) SERVICE AGREEMENT. Common law employers must assure the implementation of a Service Agreement.

(5) BENEFITS. Common law employers do not qualify for any benefits including, but not limited to, financial compenstation.

(6) COMMON LAW EMPLOYER REQUIREMENTS.

(a) Common law employers must be:

(A) The individual.

(B) A person who is designated by the individual or their legal or designated representative to act as the common law employer on behalf of the individual to meet all of the employer responsibilities described in subsection (b) of this section. The legal or designated representative of an individual may be the employer. As of October 1, 2016, no one may be a designated common law employer or proxy who does not sign a Department-approved form which affirms the designated common law employer is able to fulfill the responsibilities, or responsibilities delegated to them, as outlined in subsection (b) of this section. The designated common law employer must not have:

(i) A history of substantiated abuse of an adult as described in OAR 411-045-0250 to 411-045-0370;

(ii) A history of founded abuse of a child as described in ORS 419B.005;

(iii) A conviction of any crimes found in OAR 407-007-0280(1); or

(iv) An indictment or conviction of fraud pursuant to federal law under 42 CFR 455.23.

(C) Not currently employed as a provider in any capacity for the individual receiving services.

(D) Meet federal and state requirements to enter an employment relationship.

(b) Common law employers have the following responsibilities:

(A) Locating, screening, and hiring a qualified personal support worker.

(B) Assisting in developing the Service Agreement with the case management entity as needed.

(C) Ensuring that services are delivered in accordance with the Service Agreement.

(D) Supervising and training the personal support worker.

(E) Scheduling work, leave, and coverage.

(F) Tracking the hours worked and verifying the authorized hours completed by the personal support worker.

(G) Recognizing, discussing, and attempting to correct, with the personal support worker any performance deficiencies and provide appropriate and progressive disciplinary action as needed.

(H) Notifying the case management entity of any suspected fraud or abuse by the personal support worker.

(I) Discharging an unsatisfactory personal support worker.

(c) The Department or case management entity may be required to intervene as described in section (7) of this rule when a common law employer, designated common law employer, or common law employer proxy has demonstrated an inability to meet one or more of the employer responsibilities described in subsection (b) of this section. Indicators that an employer may not be meeting one or more of the responsibilities include, but are not limited to:

(A) Provider complaints to the case management entity or Department;

(B) Scheduling providers for more time than authorized in the Service Agreement;

(C) Scheduling multiple providers for the same time period without authorization;

(D) Approving time worked without verifying that services were delivered as described in the Service Agreement;

(E) Verifying time not actually worked by a provider;

(F) Refusal to verify time worked by a provider for services that were delivered as described in the Service Agreement;

(G) Complaints to Medicaid fraud involving the employer; or

(H) Documented observation by the case management entity or Department that services are not being delivered as identified in a Service Agreement.

(d) In the event an individual is unable or unwilling to perform the duties of a common law employer and has not already designated a common law employer, the individual or their legal or designated representative must either:

(A) Designate a common law employer proxy (proxy) as defined in OAR 411-375-0010 that meets the requirements of a common law employer in subsection (a)(B) of this section.

(i) A proxy may not be delegated all of the responsibilities of the common law employer.

(ii) The proxy may not perform any common law employer tasks not delegated to the proxy on a Department approved form.

(B) Designate a common law employer as outlined in subsection (a)(B) of this section.

(e) A designated common law employer must be able to fulfill all of the duties as outlined in subsection (b) of this section and may not utilize a designated employer proxy.

(f) If an individual is unable to fulfill the responsibilities of a common law employer and is unable to designate a proxy or other common law employer who meets the requirements outlined in subsection (a)(B) of this section, the individual may only select services from providers who are not personal support workers.

(7) INTERVENTION.

(a) For the purposes of this rule, "intervention" means the action the Department or the case management entity requires when a common law employer fails to meet the responsibilities as described in section (6)(b) of this rule.

(b) Interventions are:

(A) A review of the employer responsibilities described in section (6)(b) of this rule;

(B) Training related to employer responsibilities or referral to a Department approved resource to provide training;

(C) Corrective action taken as a result of a personal support worker filing a complaint with the Department or the case management entity; or

(D) Recommending alternative designation of common law employer responsibilities, such as a new designated common law employer or proxy.

(c) Any intervention initiated by the Department or the case management entity against a common law employer designated prior to October 1, 2016 must include the employer indicating acceptance of the common law employer responsibilities as outlined in section (6)(b) of this rule using the Department approved form.

(8) REMOVAL OF COMMON LAW EMPLOYERS.

(a) The individual or their legal or designated representative may remove a designated common law employer or proxy at any time, for any reason. Such an action by the individual or their legal or designated representative is not subject to sections (8)(b) through (9) of this rule.

(b) Prior to the removal of any common law employer by the Department or case management entity there must be at least one intervention, as described in section (7) of this rule unless:

(A) There is an imminent danger to the health and safety of the individual receiving services including:

(i) Pending charges against or conviction of the designated common law employer or proxy for any crimes found in OAR 407-007-0280(1).

(ii) An open protective services case for abuse allegations as defined in OAR 407-045-0260 against the designated common law employer or proxy.

(iii) Finding of substantiated abuse of an adult as described in OAR 411-040-0250 to 411-045-0370.

(iv) Finding of abuse of a child as described in ORS 419B.005.

(B) There is a credible allegation, indictment, or conviction of fraud pursuant to federal law under 42 CFR 455.23.

(c) The Department or case management entity shall remove any common law employer or proxy for any violation of section (6)(a)(B)(i) to (a)(B)(iv) or section (8)(b) of this rule.

(d) Any common law employer or proxy may be removed by the case management entity or Department for failure to meet the responsibilities of a common law employer as referenced in section (6)(b) after a documented intervention as outlined in section (7) of this rule.

(e) Common law employers or proxies who are removed may not act in any capacity as a common law employer or proxy for any individual receiving Department funded services effective:

(A) 30 days from the date of removal; or

(B) Immediately if removed for reasons listed under section (6)(b) of this rule.

(f) If a designated common law employer or proxy is removed the individual, or their legal or designated representative may select another designated common law employer or proxy. If a designated common law employer or proxy is not selected and the individual is unable or unwilling to serve as their own common law employer, the individual may only select providers who are not personal support workers.

(9) NOTIFICATION OF COMMON LAW EMPLOYER REMOVAL. The Department or case management entity shall notify the designated common law employer and the individual and their legal or designated representative (as applicable) of the removal of the common law employer.

(10) REQUEST FOR REINSTATEMENT OF COMMON LAW EMPLOYER STATUS.

(a) An individual, designated common law employer, or proxy is eligible to request reinstatement of their previous common law employer status if:

(A) The common law employer was the individual; or

(B) The designated common law employer or proxy no longer meets the criteria in section (8)(b) of this rule or is removed under section (8)(c) of this rule and the individual or their legal or designated representative agrees to the reinstatement.

(b) Requests for reinstatement:

(A) Must be submitted to the case management entity.

(B) Must include evidence of improvement in the areas for which they were removed. Evidence may include, but is not limited to:

(i) Improvements in health and cognitive functioning; or

(ii) Participation in a Department or case management entity approved training plan.

(C) May be approved by the case management entity when there is evidence of improvement in the ability to perform the responsibilities of being a common law employer and the individual agrees with the reinstatement.

(D) No more than one request for reinstatement may be submitted in a six month period unless approved by the case management entity.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-619, 427.007

Hist.: APD 29-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 29-2016, f. & cert. ef. 6-29-16; APD 29-2016, f. & cert. ef. 6-29-16

411-375-0070

Provider Enrollment Inactivation and Termination

(1) An independent provider may not be paid for work performed while their provider number is inactivated. A provider number for an independent provider may be inactivated by the Department until the independent provider takes action to reinstate their provider enrollment when:

(a) The independent provider has not provided any paid services to an individual within the previous 12 months;

(b) The independent provider informs the case management entity that the independent provider is no longer providing services in Oregon;

(c) For a personal support worker, the personal support worker fails to participate in a required orientation for personal support workers as described in the Collective Bargaining Agreement;

(d) The background check for an independent provider results in a closed case pursuant to OAR 407-007-0325;

(e) More than two years have passed since the date on the most recent background check final fitness determination for an independent provider;

(f) More than two years have passed since the signature date on the most recent Provider Enrollment Application and Agreement for an independent provider;

(g) The independent provider fails to participate in training required by the Department; or

(h) The independent provider does not request a hearing within 10 business days of a notice of proposed termination.

(2) An independent provider may not be paid for work performed while their provider number is inactivated during an investigation when:

(a) The independent provider, even if not providing any paid services to an individual, is being investigated for alleged violation of protective services and abuse rules by a case management entity for suspected abuse that poses imminent danger to current or future individuals;

(b) The independent provider, even if not providing any paid services to an individual, is being investigated by law enforcement for any of the crimes listed in OAR 407-007-0275; or

(c) The independent provider has a credible allegation of fraud pursuant to federal law under 42 CFR 455.23.

(3) An independent provider may not be paid for work performed while their provider number is terminated. A provider number for a independent provider may be terminated by the Department when:

(a) The independent provider violates the requirement to maintain a drug-free work place by:

(A) Being intoxicated by alcohol, inhalants, prescription drugs, or other drugs, including over-the-counter medications, while responsible for the care of an individual, while in the home of the individual, or while transporting the individual; or

(B) Manufacturing, possessing, selling, offering to sell, trading, or using illegal drugs while providing authorized services to an individual or while in the home of the individual.

(b) The independent provider has an unacceptable background check and the background check results in a closed case pursuant to OAR 407-007-0325;

(c) The independent provider demonstrates a lack of skills, knowledge, or ability to adequately or safely provide services as defined in these rules;

(d) The independent provider has a violation of the protective service and abuse rules as defined in these rules;

(e) Notwithstanding abuse as defined in OAR 407-045-0260, 411-020-0002, 943-045-0260, or child abuse and neglect as defined in OAR-413-015-0115, the independent provider fails to safely and adequately provide authorized services;

(f) The independent provider commits fiscal improprieties including, but not limited to, billing excessive or fraudulent charges or has a conviction for fraud pursuant to federal law under 42 CFR 455.23;

(g) The independent provider fails to provide services as required as defined in these rules and as described in the Service Agreement;

(h) The independent provider lacks the ability or willingness to maintain individual confidentiality;

(i) The independent provider engages in repeated unacceptable conduct at work, such as:

(A) Delay in arriving to work or absences from work not scheduled in advance with the individual or the representative of the individual that are either unsatisfactory to the individual or the representative of the individual or that neglect the service needs of the individual; or

(B) Inviting unwelcome guests or pets into the home or community with the individual resulting in the dissatisfaction of the individual or the representative of the individual or inattention to the service needs of the individual.

(j) The independent provider has been excluded or debarred by the Office of the Inspector General;

(k) The independent provider fails to perform the applicable duties as a mandatory reporter; or

(l) The independent provider fails to provide a tax identification number or social security number that matches the independent provider's legal name as verified by the Internal Revenue Service or Social Secuirty Adminstration.

(4) NOTIFICATION OF PROPOSED CHANGE IN PROVIDER NUMBER STATUS.

(a) The Department must issue a written notice of the proposed inactivation of a provider number to the independent provider when the inactivation is based on section (1)(g) or section (2) of this rule.

(b) The Department must issue a written notice of the proposed termination of a provider number to the independent provider.

(c) The Department-issued written notice of change in provider number status to the independent provider must include:

(A) An explanation of the reason for terminating or inactivating the provider number.

(B) The alleged violation as listed in sections (1) or (2) of this rule.

(C) The hearing rights, if any, of the independent provider as described in OAR 411-375-0080, including the right to legal representation, if applicable, and where to file a request for hearing.

(D) The effective date of the termination or inactivation.

(d) For terminations based on violation of the abuse and protective services rules, the written notice of termination may only contain the information allowed by law. In accordance with ORS 430.753, 430.763, and OAR 411-020-0030, the name of a complainant, witness, or alleged victim, and protected health information may not be disclosed.

(5) RETENTION OF PROVIDER NUMBER PENDING HEARING OUTCOME. The provider number of an independent provider may not be inactivated during the first 10 business days after a notice of proposed termination to provide the opportunity for the independent provider to file a request for hearing. The independent provider must file a request for hearing within 10 business days from the date of the notice of proposed termination if the independent provider wishes to continue to work during the hearing process as described in OAR 411-375-0080. If the independent provider files a written request for a hearing prior to the deadline, the provider number of the independent provider may not be inactivated or terminated until the hearing process is concluded.

(a) EXCLUSIONS. A independent provider may be terminated immediately by the Departmant and the independent provider may not continue to work during the hearing process as described in OAR 411-375-0080 when:

(A) Termination is based on a background check. The independent provider has the right to a hearing in accordance with OAR 407-007-0200 to 407-007-0370;

(B) Termination is based on being excluded or debarred by the Office of the Inspector General;

(C) Termination is based on a conviction for fraud pursuant to federal law under 42 CFR 455.23; or

(D) Termination is based on an alleged violation listed in section (3) of this rule and the alleged violation presents imminent danger to current or future individuals.

(b) The independent provider must file a request for hearing within 30 days from the date of the notice of termination as described in OAR 411-375-0080.

(6) TERMINATION IF NO HEARING REQUEST FILED.

(a) The decision of the Department becomes final if an independent provider does not request a hearing within 30 days from the date of the notice of termination.

(b) The Department will issue a Final Order by Default to the independent provider in accordance with OAR 137-003-0670. The provider enrollment for a independent provider is terminated once the time period for the independent provider to request a hearing has expired.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-619, 427.007
Hist.: APD 30-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 48-2014, f. 12-26-14, cert. ef. 12-28-14; APD 29-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 29-2016, f. & cert. ef. 6-29-16

411-375-0080
Hearing Rights

(1) EXCLUSIONS. The following are excluded from the hearings process described in this rule:

(a) Terminations based on a background check. The independent provider has the right to a hearing in accordance with OAR 407-007-0200 to 407-007-0370.

(b) Termination based on being excluded or debarred by the Office of the Inspector General.

(c) Termination based on a conviction for fraud pursuant to federal law under 42 CFR 455.23.

(d) Independent providers that have been inactivated under OAR 411-375-0070(1) or (2).

(e) Independent providers that are denied a provider enrollment number at the time of initial application.

(2) HEARING REQUESTS.

(a) A independent provider may file a request for a hearing with the Department if the independent provider disputes the decision to terminate the provider number of the independent provider except when excluded under section (1) of this rule. If an independent provider decides to file a request for hearing, the independent provider must specify in the request, the issues or decisions being disputed and the reason for the request.

(b) The request for a hearing must be filed in writing on the Department approved form with the Department within 30 days from the effective date of the termination included on the termination notice.

(3) INFORMAL CONFERENCE. The Department offers an informal conference, as described in OAR 461-025-0325, to an independent provider within five business days from the receipt of a request for hearing.

(a) The independent provider has 10 business days to respond to the offer for an informal conference with the Department.

(b) If the independent provider accepts the offer of an informal conference, the informal conference must be scheduled with the independent provider and, if requested, a legal representative. The informal conference must involve the independent provider and the Department to review the facts, and explain the decision to terminate the provider enrollment. The informal conference may be held by telephone. At the discretion of the Department representative, the Department representative may grant an additional informal conference to facilitate the hearing process.

(c) Participation in an informal conference by the independent provider is not required.

(4) The referral of a hearing request by the Department to the Office of Administrative Hearings is subject to OAR 137-003-0515.

(5) BURDEN OF PROOF. The Department has the burden of proving the decision to terminate the provider enrollment of an independent provider by a preponderance of the evidence. Evidence submitted for a hearing is governed by OAR 137-003-0610.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 410.600, 410.606-619, 427.007
Hist.: APD 30-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; APD 48-2014, f. 12-26-14, cert. ef. 12-28-14; APD 29-2015(Temp), f. 12-31-15, cert. ef. 1-1-16 thru 6-28-16; APD 29-2016, f. & cert. ef. 6-29-16

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Department of Human Services, Child Welfare Programs
Chapter 413

Rule Caption: Amending rules about the voluntary adoption registry
Adm. Order No.: CWP 10-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 6-1-2016
Rules Adopted: 413-130-0365
Rules Amended: 413-130-0000, 413-130-0300, 413-130-0310, 413-130-0320, 413-130-0330, 413-130-0340, 413-130-0350, 413-130-0355, 413-130-0360
Rules Repealed: 413-130-0400, 413-130-0420, 413-130-0430, 413-130-0440, 413-130-0450, 413-130-0455, 413-130-0460, 413-130-0480, 413-130-0490, 413-130-0500, 413-130-0510, 413-130-0520
Subject: The Department of Human Services, Office of Child Welfare Programs, is amending its rules governing the voluntary adoption registry to implement HB 2414 (2015). The bill allows the Department to add genetic siblings of adoptees to the voluntary adoption search registry and provide information regarding finalization of an adoption.

Additionally, these rules are being consolidated. Currently, the voluntary adoption registry and the assisted search program are covered in separate subdivisions. To improve organization and clarity, the rules governing the assisted search program in OAR 413-130-0400 to 413-130-0500 are being consolidated into OAR 413-130-0300 to 413-0360.

This makes permanent temporary rules adopted on January 1, 2016.

In addition, non-substantive edits were made to these rules to: ensure consistent terminology throughout child welfare program rules and policies; make general updates consistent with current Department practices; update statutory and rule references; correct formatting and punctuation; improve ease of reading; and clarify Department rules and processes.
Rules Coordinator: Kris Skaro—(503) 945-6067

413-130-0000
Definitions

The following definitions apply to rules in OAR chapter 413, division 130.

(1) "Adoptee" pursuant to ORS 109.425 means an individual who has been adopted in the State of Oregon.

(2) "Adoption" has the meaning given in OAR 413-120-0000(1).

(3) "Adoption assistance" means assistance provided on behalf of an eligible child or young adult to offset the costs associated with adopting and meeting the on-going needs of the child or young adult. "Adoption assistance" may be in the form of payments, medical coverage, reimbursement of nonrecurring expenses, or special payments.

(4) "Adoption assistance agreement" means a written agreement, binding on the parties to the agreement, between the Department and the pre-adoptive family or adoptive family of an eligible child or young adult, setting forth the assistance the Department is to provide on behalf of the child or young adult, the responsibilities of the pre-adoptive family or adoptive family and the Department, and the manner in which the agreement and amount of assistance may be modified or terminated.

(5) "Adoption assistance agreement only" means a written agreement, binding on the parties to the agreement, between the Department and the pre-adoptive family or adoptive family of an eligible child or young adult, when the pre-adoptive family or adoptive family is not receiving an adoption assistance payment or medical coverage at the time of the agreement but may request it at a later date.

(6) "Adoption assistance base rate" means the portion of the adoption assistance payment that is negotiated with a pre-adoptive family or an adoptive family and cannot exceed the amount of the Oregon foster care base rate payment for the age of the child or young adult.

(7) "Adoption assistance payment" means a monthly payment made by the Department to the pre-adoptive family or adoptive family on behalf of an eligible child or young adult.

(8) "Adoption Assistance Review Committee" means a committee composed of local and central office Department staff with expertise in the area of adoption.

(9) "Adoptive family" means an individual or individuals who have legalized a parental relationship to the child who joined the family through a judgment of the court.

(10) "Adoptive parent" means an adult who has become a parent of a child through adoption.

(11) "Agency" means a public or private organization licensed or authorized under Oregon laws to place children for adoption.

(12) "Applicable child" has the same meaning as in OAR 413-100-0335.

(13) "Assisted search" means the work carried out to locate and make confidential contact with a sought for individual upon the application of an authorized requester.

(14) "Base rate payment" means a payment to the foster parent or relative caregiver for the costs of providing the child or young adult with the following:

(a) Food, including the special or unique nutritional needs of the child or young adult;

(b) Clothing, including purchase and replacement;

(c) Housing, including maintenance of household utilities, furnishings, and equipment;

(d) Daily supervision, including teaching and directing to ensure safety and well-being at a level appropriate for the age of the child or young adult;

(e) Personal incidentals, including personal care items, entertainment, reading materials, and miscellaneous items; and

(f) Transportation, including gas, oil, and vehicle maintenance and repair costs for local travel associated with providing the items listed above, and transportation to and from extracurricular, child care, recreational, and cultural activities.

(15) "Birth parent" means:

(a) The woman or man who is legally presumed, under the laws of this state, to be the mother or father of genetic origin of a child; and

(b) A putative father of the child if the birth mother alleges he is the father and the putative father, by written affidavit or surrender and release executed within three years of the relinquishment of the child by the birth

mother or the termination of parental rights of the birth mother, acknowledges being the biological father of the child.

(16) "CANS screening" means Child and Adolescent Needs and Strengths screening, a process of gathering information on the needs and strengths of a child or young adult for one or more of the following purposes:

(a) To identify case planning, service planning, and supervision needs of the child or young adult in substitute care with a certified family;

(b) To determine the level of care payment while in substitute care with a certified family; and

(c) To determine the level of care payment included in an adoption assistance agreement or guardianship assistance agreement.

(17) "Child" means a person under 18 years of age.

(18) "Department" means the Department of Human Services, Child Welfare.

(19) "Enhanced supervision" means the additional support, direction, observation, and guidance necessary to promote and ensure the safety and well-being of a child or young adult when the child or young adult qualifies for a level of care payment.

(20) "Fee" means the maximum fixed amount that the Department or Oregon licensed adoption agency may charge to register, for requests of non-identifying information, and to conduct an assisted search.

(21) "Guardian" means an individual who has been granted guardianship of the child through a judgment of the court.

(22) "Genetic and social history" means a comprehensive report, when obtainable, of the health status and medical history of the birth parents and other individuals related to the child.

(a) The "genetic and social history" may contain as much of the following as is available:

(A) Medical history.

(B) Health status.

(C) Cause of and age at death.

(D) Height, weight, eye and hair color.

(E) Ethnic origins.

(F) Religion, if any.

(b) The "genetic and social history" may include the health status and medical history of:

(A) The birth parents.

(B) A putative father, if any.

(C) Siblings to the birth parents, if any.

(D) Siblings to a putative father, if any.

(E) Other children of either birth parent, if any.

(F) Other children of a putative father, if any.

(G) Parents of the birth parents.

(H) Parents of a putative father, if any.

(23) "Health history" means a comprehensive report, when obtainable, of the health status and medical history of the child at the time of placement for adoption, including neonatal, psychological, physiological, and medical care history.

(24) "Identifying information" means names and addresses of birth parents, putative fathers, adult adoptee, and adult adoptee genetic siblings.

(25) "Independent adoption" means any adoption where the consent is given by other than the Department or a licensed adoption agency.

(26) "Legally free" means that, with respect to a child, the legal rights of all parents with legal standing have been judicially terminated, voluntarily relinquished, or otherwise terminated by operation of law, thus allowing for the child to be adopted.

(27) "Level of care payment" means the payment provided to an approved or certified family, a guardian, a pre-adoptive family, or an adoptive family based on the need for enhanced supervision of a child or young adult determined by applying the CANS algorithm to the results of the CANS screening.

(28) "Licensed adoption agency" means an:

(a) Approved child-caring agency of this state acting by authority of ORS 418.270 and OAR 413-215-0401 to 413-215-0481; and

(b) Agency or other organization that is licensed, or otherwise authorized, to provide adoption services pursuant to the laws of that state, country, or territory.

(29) "Non-identifying information" means genetic and social history and health history which excludes information identifying any birth parent, birth family, putative father, putative father's family, adoptee, or adoptive parent.

(30) "Nonrecurring adoption assistance agreement" means a written agreement, binding on the parties to the agreement, between the Department and the pre-adoptive family of an eligible child for a one-time payment to reimburse the adoptive family for the reasonable and necessary expenses incurred in legally finalizing the adoption of a child who has been determined to have special needs.

(31) "Nonrecurring expenses" mean a one-time payment up to $2,000 per child, which the Department will pay to an adoptive family to assist with the reasonable and necessary expenses incurred in legally finalizing the adoption of an eligible child.

(32) "Parent" means the biological or adoptive mother or the legal father of the child. A legal father is a man who has adopted the child or whose paternity has been established or declared under ORS 109.070, ORS 416.400 to 416.465, or by a juvenile court. In cases involving an Indian child under the Indian Child Welfare Act (ICWA), a legal father includes a man who is a father under applicable tribal law.

(33) "Participating tribe" means a federally-recognized Indian tribe in Oregon with a Title IV-E agreement with the Department.

(34) "Pre-adoptive family" means an individual or individuals who:

(a) Has been selected to be the adoptive family of the child; and

(b) Is in the process of legalizing the relationship to the child through the judgment of the court.

(35) "Progeny" means the children or descendants of a person and the person's descendants in successive generations.

(36) "Putative father" means a man who, under the laws of this state, is not legally presumed to be the father of genetic origin of a child, but who claims or is alleged to be the father of genetic origin of the child.

(37) "Qualified alien" has the same meaning as in OAR 413-100-0210(2) and 8 USC 1641(b).

(38) "Qualified vendor attorney" means an attorney who has a price agreement with the Department to process the adoption of a child who is eligible for adoption assistance.

(39) "Registry" means a voluntary adoption registry established under ORS 109.450 and maintained by:

(a) An Oregon licensed adoption agency or successor agency; or

(b) The Department for all adoptions not arranged through an Oregon licensed adoption agency.

(40) "Requester" means an individual duly registered on a voluntary adoption registry who requests an assisted search, and who has filed an application and paid the applicable fee.

(41) "Searcher" means one of the following qualified entities that may conduct an assisted search:

(a) The Department;

(b) An Oregon licensed adoption agency; or

(c) A third party individual or entity who has been delegated to or contracted with by the Department or an Oregon licensed adoption agency.

(42) "Sibling" means one of two or more children or young adults who are related, or would be related but for a termination or other disruption of parental rights, in one of the following ways:

(a) By blood or adoption through a common parent;

(b) Through the marriage of the legal or biological parents of the children or young adults; or

(c) Through a legal or biological parent who is the registered domestic partner of the legal or biological parent of the children or young adults.

(43) "Special payment" means a payment for unanticipated short-term costs which are directly related to the special needs of the child or young adult or are essential to the welfare of the child or young adult, and are not covered by another resource available to the adoptive family.

(44) "Substitute care" means the out-of-home placement of a child or young adult who is in the legal or physical custody and care of the Department.

(45) "Successor agency" means an agency which has the adoption records of another agency because of the merger of the agencies or because an agency has ceased doing business and has given its adoptions records to the "successor agency" as provided an ORS 109.435(2).

(46) "Voluntary adoption registry" means a voluntary registry operated by the Department or licensed adoption agency:

(a) Where birth parents, putative fathers, and adult adoptees may register their willingness to the release of identifying information to each other;

(b) That provides for the disclosure of identifying information to birth parents and their genetic offspring;

(c) That provides for the transmission of non-identifying health and social and genetic history of specified persons; and

(d) That provides for the disclosure of specific identifying information under certain circumstances to Indian tribes, governmental agencies, or to an individual settling an estate.

(47) "Work Product" means any records, information, or other materials obtained or developed by the Department or licensed adoption agency during the course of the assisted search.

(48) "Young adult" means a person aged 18 through 20 years.

Stat. Auth.: ORS 418.005, 418.340
Stats. Implemented: ORS 418.005, 418.330, 418.335 & 418.340
Hist.: SCF 2-1995, f. & cert. ef. 8-21-95; SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 8-1999, f. & cert. ef. 5-17-99; SOSCF 7-2002, f. 3-28-02, cert. ef. 4-1-02; CWP 23-2005(Temp), f. 12-30-05, cert. ef. 1-1-06; CWP 16-2006, f. 6-30-06, cert. ef. 7-1-06; CWP 16-2008, f. & cert. ef. 7-1-08; CWP 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; CWP 22-2009, f. & cert. ef. 12-29-09; CWP 16-2011(Temp), f. & cert. ef. 6-30-11 thru 12-27-11; CWP 25-2011(Temp), f. 9-30-11, & cert. ef. 10-1-11 thru 12-27-11; CWP 35-2011, f. 12-27-11, cert. ef. 12-28-11; CWP 2-2014, f. 1-31-14, cert. ef. 2-1-14; CWP 11-2015(Temp), f. & cert. ef. 5-22-15 thru 11-17-15; CWP 24-2015, f. & cert. ef. 10-26-15; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0300
Purpose

The purpose of OAR 413-130-0300 to 413-130-0365 is to describe the responsibilities of the Adoption Search and Registry Program for adoptions that finalized in Oregon and the eligibility requirements that must be met in order to:

(1) Receive non-identifying information from the registry;

(2) Register to allow the release of identifying information; and

(3) Request an assisted search for certain members of an individual's birth family or the county in which the adoption was finalized.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 10-1998, f. 4-27-98, cert. ef. 5-1-98; SOSCF 30-2000, f. & cert. ef. 11-7-00; SOSCF 49-2001, f. 12-31-01 cert. ef. 1-1-02; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0310
Registry Eligibility for Non-Identifying Information

(1) A registry must provide genetic and social history and health history of the adoptee and birth family members, if available, to the following individuals:

(a) An adult adoptee;

(b) An adoptive parent of a child adoptee;

(c) A guardian of a child adoptee;

(d) A birth parent of an adoptee;

(e) Adult progeny of a deceased adoptee;

(f) A spouse of a deceased adoptee, if the spouse is the birth parent or guardian of any child of the adoptee.

(2) An eligible individual must request non-identifying information by submitting a request form provided by the registry and a $45 fee.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 10-1998, f. 4-27-98, cert. ef. 5-1-98; SOSCF 30-2000, f. & cert. ef. 11-7-00; SOSCF 49-2001, f. 12-31-01 cert. ef. 1-1-02; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0320
Registry Eligibility for Identifying Information

(1) The adoption registry is a voluntary program in which birth parents, putative fathers, adoptees, and genetic siblings of adoptees may register their willingness to release identifying information to each other.

(2) The following individuals are eligible to register:

(a) An adult adoptee;

(b) An adoptive parent or guardian of a minor adoptee;

(c) An adoptive parent of a deceased adoptee;

(d) An adult genetic sibling of an adoptee;

(e) A parent or guardian of a minor genetic sibling of an adoptee;

(f) A birth parent;

(g) A parent or adult sibling of a deceased birth parent; or

(h) A putative father. A putative father may register to have his identifying information given to adult adoptee, but the registry may not give identifying information about the adoptee to the putative father.

(3) The registry must allow the adult progeny or the parent or guardian of a minor progeny of the following individuals to register:

(a) A deceased adoptee;

(b) A deceased genetic sibling of an adoptee;

(c) A deceased birth parent of an adoptee.

(4) An eligible individual must register by submitting the following to the applicable registry:

(a) A notarized affidavit on a form provided by the registry;

(b) A copy of his or her birth certificate; and

(c) A $25 fee.

(5) A registrant may cancel the registration at any time with written notice to the registry.

(6) Registration by a parent or guardian of a minor expires when the minor reaches 18 years of age. The adult adoptee must reregister for identifying information to be released to relevant individuals who are registered. The registry program may not charge a fee for reregistration.

(7) The registrant must notify the registry of any change of name or address.

(8) The registry will notify the registrants when a match is identified. A registry may recommend appropriate counseling prior to the release of information to the eligible individual.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 30-2000, f. & cert. ef. 11-7-00; SOSCF 49-2001, f. 12-31-01 cert. ef. 1-1-02; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0330
Assisted Search Program Eligibility

(1) The following individuals may request an assisted search for a birth parent, a putative father, a genetic sibling of an adoptee, or the county in which an adoption was finalized:

(a) An adult adoptee;

(b) An adoptive parent of a minor adoptee; or

(c) An adoptive parent of a deceased adoptee.

(2) The following individuals may request an assisted search for an adult adoptee:

(a) Except as provided in section (4) of this rule, a birth parent if the adult adoptee does not have any minor genetic siblings in the same adoptive family;

(b) An adult genetic sibling of an adoptee; or

(c) A parent or adult sibling of a deceased birth parent.

(3) Except as provided in section (4) of this rule, a birth parent may request a search for the county in which the adoption was finalized. At the discretion of the Department or agency, a search may be conducted.

(4) A putative father may not request an assisted search.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 10-1998, f. 4-27-98, cert. ef. 5-1-98; SOSCF 30-2000, f. & cert. ef. 11-7-00; SOSCF 49-2001, f. 12-31-01 cert. ef. 1-1-02; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0340
Assisted Search Application Requirements

(1) Individuals requesting an assisted search must submit the following:

(a) An application on an approved form to the applicable registry. The Department may disclose the applicable registry if it is unknown by the requester.

(b) Proof of registration for identifying information with the registry; and

(c) A fee of $400 for the first individual and $200 for each additional individual.

(2) Upon receipt of a completed application the registry must do all of the following:

(a) Prepare a search file.

(b) Assign the case to a searcher.

(c) Inform the requester that the case has been opened and provide periodic updates on the status of the search.

(3) Duties of the Searcher.

(a) When an individual is located, the searcher must:

(A) Make a confidential inquiry to determine if the located individual wants to establish contact with the requester;

(B) Inform the located individual about the registry program, explain that participation is voluntary and no identifying information will be released unless they have registered with the appropriate registry; and

(C) If the requester is searching because there is a serious medical condition in the individual's immediate family that is, or may be, an inheritable condition and the located individual is biologically related to the ill individual, inform the located individual.

(b) Upon completion of the search, the searcher must:

(A) Notify the registry of the results of the search; and

(B) Return or confidentially dispose of any information obtained in connection with the search.

(4) When notified of the results of a search, the registry must:

(a) Provide registration to a located individual who wants to register;

(b) Notify the requester of the results of the search;

(c) Record the results of the search;

(d) Include any information from the searcher in the search file; and

(e) If the located individual has not returned the registration materials within 90 days, the registry may, where practicable, contact the located individual one time to determine if the located individual still intends to register.

(5) Upon receipt of registration materials from the located individual, the registry must contact both the requester and the located individual to assure that communication is initiated in a way that is acceptable for each individual. The registry must only release contact information that is allowed by each registrant.

(6) The registry must complete the assisted search within 120 days from the date of assignment. If the search is not completed within 120 days, the registry must contact the requester and provide the reason for the delay and a projected completion date.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 30-2000, f. & cert. ef. 11-7-00; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0350
Standards of Conduct for a Registry

A registry must do all of the following:

(1) Maintain accurate and complete records of each search.

(2) Keep confidential all adoption file information and all work product developed during an assisted search process.

(3) Only contact adoptees, birth family members, or adoptive family members under the provisions of these rules.

(4) Act within applicable statutory and administrative rules.

(5) Not contact, exert pressure, or in any other way solicit an adoptee, adoptive parent or guardian, birth parent, or putative father to register with the registry except as allowed in relation to an assisted search.

(6) Accept fees not exceeding those described these rules.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 10-1998, f. 4-27-98, cert. ef. 5-1-98; SOSCF 30-2000, f. & cert. ef. 11-7-00; SOSCF 49-2001, f. 12-31-01 cert. ef. 1-1-02; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0355
Standards for a Searcher

Individuals or entities who perform assisted searches for a registry must do all of the following:

(1) Keep all information from sealed adoption files and information obtained during an assisted search confidential.

(2) Maintain accurate and complete records of each search.

(3) Work within the boundaries of applicable statutory and administrative rules.

(4) Avoid potential conflicts of interest in conducting a search.

(5) Provide a criminal background check demonstrating no record of criminal convictions related to maintaining the integrity or confidentiality of records or child abuse or other offenses involving minor children.

(6) Sign a statement of confidentiality that outlines potential civil and criminal penalties for any disclosure of file information to any one not expressly authorized in applicable statutes or administrative rules.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: SOSCF 30-2000, f. & cert. ef. 11-7-00; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0360
Access to Registry Records

(1) A licensed adoption agency may examine adoption records maintained by the Department as part of an assisted search.

(2) The Department may examine adoption records maintained by a licensed adoption agency as part of an assisted search if the licensed adoption agency so allows.

(3) Original file contents or copies of confidential documents may not be removed from a registry.

(4) A searcher may not inspect any other files of another registry except those directly related to the file of the requester.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; SOSCF 30-2000, f. & cert. ef. 11-7-00; SOSCF 49-2001, f. 12-31-01 cert. ef. 1-1-02; CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

413-130-0365
Confidentiality and Maintenance of Records

(1) All information acquired by the registry must be confidential and be disclosed only as provided in these rules or pursuant to a court order.

(2) Registry files including work product from an assisted search must be maintained permanently.

(3) If a licensed adoption agency ceases to do business, the agency must transfer the adoption records to the Department or a successor agency. If files are transferred to a successor agency, the agency must tell the Department who has the files.

Stat. Auth.: ORS 109.506, 418.005
Stats. Implemented: ORS 109.425 - 109.507
Hist.: CWP 1-2016(Temp), f. & cert. ef. 1-1-16 thru 6-28-16; CWP 10-2016, f. & cert. ef. 6-29-16

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Rule Caption: Implementation of SB 1515 (2016)
Adm. Order No.: CWP 11-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Adopted: 413-015-0620, 413-015-0625, 413-015-0630, 413-015-0640, 413-080-0051, 413-080-0070
Rules Amended: 413-015-0100, 413-015-0115, 413-015-0125, 413-015-0205, 413-015-0210, 413-015-0211, 413-015-0212, 413-015-0215, 413-015-0300, 413-015-0409, 413-015-0415, 413-015-0420, 413-015-0440, 413-015-0445, 413-015-0450, 413-015-0470, 413-015-1000, 413-015-9030, 413-015-9040, 413-080-0050, 413-080-0052, 413-080-0054, 413-080-0059, 413-090-0000, 413-090-0055, 413-090-0065, 413-090-0070, 413-090-0075, 413-090-0080, 413-090-0087, 413-090-0090
Rules Suspended: 413-015-0215(T)
Subject: The Department of Human Services, Office of Child Welfare Programs, is adopting temporary rules to implement SB 1515 (Oregon Laws 2016, chapter 2016.) The new law creates new requirements for the Department relating to ensuring the safety of children residing in or receiving services from child-caring agencies licensed by the Department.

Child Protective Services:

These rules establish requirements for screeners and CPS (Child Protective Services) workers when reports of abuse or neglect are received by the Department. The rules are being amended to state that when a report is received and the information indicates it involves a child-caring agency, screeners will be directed to new rules, OAR 413-015-0620 through 413-015-0640, which will state responsibilities and requirements for responding to these reports. Specifically, reports will be screened under a new definition of abuse in section 36 of SB 1515; the Department will respond to reports on children through age 20; screeners and CPS workers will notify appropriate Department personnel to ensure notifications required by SB 1515 are made; and CPS workers will collaborate with appropriate personnel to share information and determine the appropriate Department response to ensure child safety.

Monthly Contact and Monitoring Child and Young Adult Safety:

These rules describe the responsibilities of the Department regarding monthly contact with children and young adults in Department custody, monitoring the safety, permanency, and well-being needs, and monitoring the ongoing safety plan. These rules are being amended to require Department staff to notify appropriate personnel when they have concerns, including when well-being needs are not being met, about a child or young adult residing in or receiving services from a child-caring agency or proctor foster home. Definitions are also amended to align with SB 1515. Additionally, OAR 413-080-0070 is adopted to establish the persons and entities who must be notified whenever the Department receives reports of abuse or licensing or contracting violations about a child-caring agency or when the Department takes certain actions on a child-caring agency license.

Behavior Rehabilitation Services:

These rules describe the requirements for BRS (Behavior Rehabilitation Services) contractors who provide BRS services to children. The rules are being amended to require the Department to immediately investigate and take appropriate actions when the Department receives reports of abuse or licensing or contracting vio-

lations. The BRS program office will also investigate to determine if any material breach of the terms of the BRS contract have occurred and take appropriate action. Additionally, BRS contractors and providers, including proctor foster homes, will be required to permit immediate access to a child in their care and to the premises as provided in ORS 418.305 as amended by section 20 of SB 1515. BRS contractors will also be required to comply with all law and regulations, including new SB 1515 licensing requirements in OAR chapter 413, division 2015. Definitions in these rules are also amended to align with SB 1515.

The rule text showing these proposed changes is available at http://www.dhs.state.or.us/policy/childwelfare/implement/temp_rules.htm.

The Department is amending additional rules to implement SB 1515, including rules for the Office of Licensing and Regulatory Oversight, the Office of Adult Abuse Prevention and Investigations, and the Background Check Unit. More information is available on the SB 1515 implementation webpage at https://www.oregon.gov/DHS/CHILDREN/Pages/sb1515.aspx.

Rules Coordinator: Kris Skaro—(503) 945-6067

413-015-0100

Child Protective Service Authority and Responsibility

Reports of alleged child abuse or neglect are received by the Department and screened for Department response. The processes and time lines for completion are provided in division 015 of this chapter of rules, and also in OAR chapter 407, division 045 for the child-caring agencies or proctor foster homes screened and investigated by the Office of Adult Abuse Prevention and Investigation. OAR 413-015-0100 to 413-015-0125 provide an overview of division 015, which implements ORS 409.185, 418.015, and 419B.005 to 419B.050.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 409.185, 418.005, 418.015 & 419B.005 - 419B.050, OL 2016, ch 10

Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 22-2007(Temp), f. & cert. ef. 12-3-07 thru 4-11-08; CWP 2-2008, f. & cert. ef. 4-1-08; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0115

Definitions

Unless the context indicates otherwise, these terms are defined for use in OAR chapter 413, division 015:

(1) "Caregiver" means a guardian, legal custodian, or other person acting in loco parentis, who exercises significant authority over and responsibility for a child.

(2) "Child" means a person who:

(a) Is under 18 years of age; or

(b) Is under 21 years of age and residing in or receiving care or services at a child-caring agency.

(3) "Child abuse or neglect" means any form of child abuse, including abuse through neglect and abuse or neglect by a third party, as defined in ORS 419B.005 or, when applicable, Oregon Laws 2016, chapter 106, section 36.

(4) "Child-caring agency" is defined in ORS 418.205 and:

(a) Means any private school, private agency, or private organization providing:

(A) Day treatment for children with emotional disturbances;

(B) Adoption placement services;

(C) Residential care, including but not limited to foster care or residential treatment for children;

(D) Residential care in combination with academic education and therapeutic care, including but not limited to treatment for emotional, behavioral or mental health disturbances;

(E) Outdoor youth programs; or

(F) Other similar care or services for children.

(b) Includes the following:

(A) A shelter-care home that is not a foster home subject to ORS 418.625 to 418.645;

(B) An independent residence facility as described in ORS 418.475;

(C) A private residential boarding school; and

(D) A child caring facility as defined in ORS 418.950.

(c) Child-caring agency does not include:

(A) Residential facilities or foster care homes certified or licensed by the Department of Human Services under ORS 443.400 to 443.455, 443.830 and 443.835 for children receiving developmental disability services;

(B) Any private agency or organization facilitating the provision of respite services for parents pursuant to a properly executed power of attorney under ORS 109.056. For purposes of this subsection, "respite services" means the voluntary assumption of short-term care and control of a minor child without compensation or reimbursement of expenses for the purpose of providing a parent in crisis with relief from the demands of ongoing care of the parent's child;

(C) A youth job development organization as defined in ORS 344.415;

(D) A shelter-care home that is a foster home subject to ORS 418.625 to 418.645; or

(E) A foster home subject to ORS 418.625 to 418.645.

(5) "Child protective services" (CPS) means a specialized social service program that the Department provides on behalf of children who may be unsafe after a report of child abuse or neglect is received.

(6) "Child protective services assessment" (CPS assessment) means an investigation into a report of child abuse or neglect pursuant to ORS 419B.020 that includes activities and interventions to identify and analyze threats to child safety, determine if there is reasonable cause to believe child abuse or neglect occurred, and assure child safety through protective action plans, initial safety plans, or ongoing safety planning.

(7) "Child protective services supervisor" (CPS supervisor) means an employee of the Department trained in child protective services and designated as a supervisor.

(8) "Child protective services worker" (CPS worker) means an employee of the Department who has completed the mandatory Department training for child protective service workers.

(9) "Child Safety Meeting" means a meeting held at the conclusion of a CPS assessment for the purpose of developing an ongoing safety plan.

(10) "Conditions for return" means a written statement of the specific behaviors, conditions, or circumstances that must exist within a child's home before a child can safely return and remain in the home with an in-home ongoing safety plan.

(11) "Day Care Facility" means each of the following:

(a) A Registered Family Child Care Home, which is the residence of a provider who has a current Family Child Care Registration at that address and who provides care in the family living quarters.

(b) A Certified Family Child Care Home, which is a child care facility located in a building constructed as a single family dwelling that has certification to care for a maximum of 16 children at any one time.

(c) A Certified Child Care Center, which is certified to care for 13 or more children, or a facility that is certified to care for twelve or fewer children and located in a building constructed as other than a single family dwelling.

(d) A Listed Facility, which is a child care provider that is exempt from Office of Child Care licensing and that receives subsidy payments for child care on behalf of clients of the Department of Human Services.

(12) "Department" means the Department of Human Services, Child Welfare.

(13) "Department response" means how the Department intends to respond to information that a child is unsafe after a report of alleged abuse or neglect is received.

(14) "Designated medical professional" means (as described in ORS 418.747(9)) a physician, physician assistant, or nurse practitioner who has been designated by the local multi-disciplinary team and trained to conduct child abuse medical assessments (as defined in ORS 418.782), and who is -- or who may designate another physician, physician assistant, or nurse practitioner who is -- regularly available to conduct these medical assessments.

(15) "Domestic violence" means a pattern of coercive behavior, which can include physical, sexual, economic, and emotional abuse that an individual uses against a past or current intimate partner to gain power and control in a relationship.

(16) "Face-to-face" means an in-person interaction between individuals.

(17) "Former foster child" means a person under 21 years of age who was in substitute care at or after 16 years of age, including substitute care provided by federally recognized tribes, and had been in substitute care for at least 180 cumulative days after 14 years of age.

(18) "Founded" means there is reasonable cause to believe that child abuse or neglect, as defined in ORS 419B.005, occurred.

(19) "Guardian" means an individual who has been granted guardianship of a child through a judgment of the court.

(20) "Harm" means any kind of impairment, damage, detriment, or injury to a child's physical, sexual, psychological, cognitive, or behavioral development or functioning. "Harm" is the result of child abuse or neglect and may vary from mild to severe.

(21) "ICWA" means the Indian Child Welfare Act.

(22) "Impending danger safety threat" means a family behavior, condition, or circumstance that meets all five safety threshold criteria. A threat to a child that is not immediate, obvious, or occurring at the onset of the CPS intervention. This threat is identified and understood more fully by evaluating and understanding individual and family functioning.

(23) "Initial contact" means the first face-to-face contact between a CPS worker and a family. The initial contact includes face-to-face contact with the alleged child victim, his or her siblings, parent or caregiver, and other children and adults living in the home; accessing the home environment; and gathering sufficient information on the family conditions and functioning to determine if present danger safety threats or impending danger safety threats exist.

(24) "Initial safety plan" means a documented set of actions or interventions sufficient to protect a child from an impending danger safety threat in order to allow for completion of the CPS assessment.

(25) "Moderate to high needs" means observable family behaviors, conditions, or circumstances that are occurring now; and over the next year without intervention, are likely to have a negative impact on a child's physical, sexual, psychological, cognitive, or behavioral development or functioning. The potential negative impact is not judged to be severe. While intervention is not required for the child to be safe, it is reasonable to determine that short-term, targeted services could reduce or eliminate the likelihood that the negative impact will occur.

(26) "Monthly face-to-face contact" means in-person interaction between individuals at least once each and every full calendar month.

(27) "Multi-disciplinary team" (MDT) means a county child abuse investigative team as defined in ORS 418.747.

(28) "Observable" means specific, real, can be seen and described. Observable does not include suspicion or gut feeling.

(9) "Ongoing safety plan" means a documented set of actions or interventions that manage a child's safety after the Department has identified one or more impending danger safety threats at the conclusion of a CPS assessment or anytime during ongoing work with a family.

(30) "Out of control" means family behaviors, conditions, or circumstances that can affect a child's safety are unrestrained, unmanaged, without limits or monitoring, not subject to influence or manipulation within the control of the family, resulting in an unpredictable and chaotic family environment.

(31) "Personal representative" means a person who is at least 18 years of age and is selected to be present and supportive during the CPS assessment by a child who is the victim of a person crime as defined in ORS 147.425 and is at least 15 years of age at the time of the crime. The personal representative may not be a person who is a suspect in, party or witness to, the crime.

(32) "Pre-adoptive family" means an individual or individuals who:

(a) Has been selected to be a child's adoptive family; and

(b) Is in the process of legalizing the relationship to the child through the judgment of the court.

(33) "Present danger safety threat" means an immediate, significant, and clearly observable family behavior, condition, or circumstance occurring in the present tense, already endangering or threatening to endanger a child. The family behavior, condition, or circumstance is happening now and it is currently in the process of actively placing a child in peril.

(34) "Proctor foster home" means a foster home certified by a child-caring agency that is not subject to ORS 418.625 to 418.470.

(35) "Protective action plan" means an immediate, same day, short-term plan, lasting a maximum of ten calendar days, sufficient to protect a child from a present danger safety threat.

(36) "Protective capacity" means behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person's ability and willingness to care for and keep a child safe.

(37) "Protective custody" means custody authorized by ORS 419B.150.

(38) "Reasonable suspicion" means a reasonable belief given all of the circumstances, based upon specific and describable facts, that the suspicious physical injury may be the result of abuse. Explanation: The belief must be subjectively and objectively reasonable. In other words, the person subjectively believes that the injury may be the result of abuse, and the belief is objectively reasonable considering all of the circumstances. The circumstances that may give rise to a reasonable belief may include, but not be limited to, observations, interviews, experience, and training. The fact that there are possible non-abuse explanations for the injury does not negate reasonable suspicion.

(9) "Referral" means a report that has been assigned for the purpose of CPS assessment.

(40) "Report" means an allegation of child abuse or neglect provided to the Department that the screener evaluates to determine if it constitutes a report of child abuse or neglect as defined in ORS 419B.005 or, when applicable, Oregon Laws 2016, chapter 106, section 36.

(41) "Reporter" means an individual who makes a report.

(42) "Safe" means there is an absence of present danger safety threats and impending danger safety threats.

(43) "Safety service provider" means a participant in a protective action plan, initial safety plan, or ongoing safety plan whose actions, assistance, or supervision help a family in managing a child's safety.

(44) "Safety services" mean the actions, assistance, and supervision provided by safety service providers to manage the identified present danger safety threats or impending danger safety threats to a child.

(45) "Safety threshold" means the point at which family behaviors, conditions, or circumstances are manifested in such a way that they are beyond being risk influences and have become an impending danger safety threat. In order to reach the "safety threshold" the behaviors, conditions, or circumstances must meet all of the following criteria: be imminent, be out of control, affect a vulnerable child, be specific and observable, and have potential to cause severe harm to a child. The "safety threshold" criteria are used to determine the presence of an impending danger safety threat.

(46) "School administrator" means the principal, vice principal, assistant principal, or any other person performing the duties of a principal, vice principal, or assistant principal at a school, as defined in the Teacher Standards and Practices Commission (TSPC) OAR 584-005-0005.

(47) "Screener" means a Department employee with training required to provide screening services.

(48) "Screening" means the process used by a screener to determine the Department response when information alleging abuse or neglect is received.

(49) "Severe harm" means:

(a) Significant or acute injury to a child's physical, sexual, psychological, cognitive, or behavioral development or functioning;

(b) Immobilizing impairment; or

(c) Life threatening damage.

(50) "Substance" means any controlled substance as defined by ORS 475.005, prescription medications, over-the-counter medications, or alcoholic beverages.

(51) "Substantiated" means there is reasonable cause to believe that child abuse, as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106, section 36, occurred.

(52) "Suspicious physical injury" (as defined in ORS 419B.023) includes, but is not limited to:

(a) Burns or scalds;

(b) Extensive bruising or abrasions on any part of the body;

(c) Bruising, swelling, or abrasions on the head, neck, or face;

(d) Fractures of any bone in a child under the age of three;

(e) Multiple fractures in a child of any age;

(f) Dislocations, soft tissue swelling, or moderate to severe cuts;

(g) Loss of the ability to walk or move normally according to the child's developmental ability;

(h) Unconsciousness or difficulty maintaining consciousness;

(i) Multiple injuries of different types;

(j) Injuries causing serious or protracted disfigurement or loss or impairment of the function of any bodily organ; or

(k) Any other injury that threatens the physical well-being of the child.

(53) "Teacher" means (as defined in TSPC OAR 584-005-0005) a licensed or registered employee in a public school or charter school, or employed by an education service district, who has direct responsibility for instruction, coordination of educational programs, or supervision or evaluation of teachers; and who is compensated for services from public funds.

(54) "Third-party abuse" means abuse by a person who is not the child's parent, not the child's caregiver or other member of the child's household, and not a person responsible for the child's care, custody, and control. Examples of persons who could be considered as a third-party under this definition include school personnel, day-care providers, coaches, and church personnel.

(55) "Unsafe" means the presence of a present danger safety threat or an impending danger safety threat.

(56) "Vulnerable child" means a child who is unable to protect him or herself. This includes a child who is dependent on others for sustenance and protection. A "vulnerable child" is defenseless, exposed to behaviors, conditions, or circumstances that he or she is powerless to manage, and is susceptible and accessible to a threatening parent or caregiver. Vulnerability is judged according to physical and emotional development, ability to communicate needs, mobility, size, and dependence.

(57) "Young adult" means a person aged 18 through 20 years.

Stat. Auth.: ORS 409.185, 418.005, 418.747, 419B.017, 419B.024, 419B.035

Stats. Implemented: ORS 147.425, 409.185, 418.005, 418.015, 418.747, 419B.005 - 419B.050

Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 14-2004, f. 7-30-04, cert. ef. 8-1-04; CWP 17-2004, f. & cert. ef. 11-1-04; CWP 4-2005, f. & cert. ef. 2-1-05; CWP 19-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-30-06; CWP 14-2006, f. 6-30-06, cert. ef. 7-1-06; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 16-2007(Temp), f. & cert. ef. 10-16-07 thru 4-11-08; CWP 22-2007(Temp), f. & cert. ef. 12-3-07 thru 4-11-08; CWP 24-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 4-11-08; CWP 2-2008, f. & cert. ef. 4-1-08; CWP 5-2010(Temp), f. & cert. ef. 6-15-10 thru 12-12-10; CWP 21-2010, f. & cert. ef. 11-15-10; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 13-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; CWP 17-2014, f. & cert. ef. 12-24-14; CWP 18-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 3-28-16; CWP 27-2015, f. 12-28-15, cert. ef. 1-1-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0125
Department CPS Responsibility Ends

The Department is not responsible for providing child protective services when:

(1) A screener determines that information received during screening does not meet the statutory definition of child abuse or neglect (see OAR 413-015-0210(2)(a) and (b));

(2) The CPS assessment has determined the child is safe; or

(3) The CPS assessment does not identify information sufficient to request juvenile court intervention or the CPS assessment has determined the child is unsafe and the juvenile court declines to intervene, and the parents or caregivers do not request or agree to cooperatively receive services.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 418.005

Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0205
Screening Activities

The screener must complete the following activities:

(1) Gather information. When gathering information, the screener must do both of the following:

(a) Accept reports of child abuse or neglect regardless of where the child resides or where the alleged child abuse or neglect may have occurred. If the report is about a child that does not reside in the county where the report is received, the screener must forward the completed screening report form to the local child welfare office in the county or state where the child resides. The screener must forward the screening report form on the same day the report is received and confirm that it has been successfully forwarded.

(b) Accept and handle anonymous reports of child abuse or neglect in the same manner as other reports, gather the same information from the anonymous reporter as the screener would from any other reporter, and encourage the reporter to provide identifying information.

(2) If appropriate, refer the person to community services and resources.

(3) Determine the type of information received, Child Protective Services or Family Support Services, and where and when to document the information received.

(a) Child Protective Services. This type of information is related to reports of alleged child abuse or neglect.

(A) Child Protective Services information is documented in the Department's electronic information system.

(B) The time line for screeners to complete and document their actions, and document information gathered, unless a CPS supervisor grants the screener an extension as provided in OAR 413-015-0220, is:

(i) Immediately when a "within 24 hours" response time line is assigned;

(ii) Within the same day when a "within five days" response time line is assigned; or

(iii) No later than the next working day after the screening determination is made when the report is closed at screening.

(b) Family Support Services. This type of information is not a report of alleged child abuse or neglect, and it does not include information that indicates a child is unsafe.

(A) This information is documented in the Department's electronic information system using a screening report form.

(B) The time line for screeners to complete and document their actions, and document information gathered is within two days of receiving the request for services.

(C) Family Support Services information falls within one of the categories described below:

(i) Request for Placement — Information falls within this category when:

(I) A parent or guardian requests out-of-home placement of their child due solely to obtain services for the emotional, behavioral, or mental disorder or developmental or physical disability of the child;

(II) The parent or guardian requests the Department take legal custody of their child; or

(III) The court has ordered a pre-adjudicated delinquent into the care of the Department.

(ii) Request for Independent Living Program Services — Information falls within this category when a former foster child qualifies for Independent Living Program (ILP) services, is not a participant on an open case, and requests to enroll in the Department's ILP.

(iii) Request for Post Legal Adoption and Post Guardianship Services -- Information falls within this category when a family requests post legal adoption or post guardianship services, if the adoption or guardianship occurred through the Department.

(iv) Request for Voluntary Services — Information falls within this category when it does not meet the criteria in subparagraphs (i), (ii), or (iii) of this paragraph, a parent or caregiver requests assistance with a child in the home, and all of the following apply:

(I) Other community resources have been utilized and determined to be ineffective.

(II) Members of the extended family and other responsible adults who are well known to the child have been explored or utilized and determined to be unsafe, unavailable, unwilling, or ineffective as support for the family.

(III) The parent or caregiver is temporarily or will be temporarily unable to fulfill parental responsibilities due to a diagnosed medical condition or a mental health diagnosis.

(IV) The parent's or caregiver's inability to fulfill parental responsibilities is temporary and immediate, and will be alleviated with short term services or short term services will transition the family to community services.

(V) A Child Welfare program manager approves the request for voluntary services.

(4) When the screener receives Child Protective Services information, the screener must complete the screening activities described below.

(a) The screener must gather the following information, which is critical to effectively identify if there is a report of child abuse or neglect as defined in ORS 419B.005 or, when applicable, Oregon Laws 2016, chapter 106, section 36 and if the information alleges that behaviors, conditions, or circumstances could result in harm to the child:

(A) The type of alleged child abuse or neglect and the circumstances surrounding the report;

(B) How the alleged child abuse or neglect or the surrounding circumstances are reported to affect the safety of the child;

(C) Information that identifies how the child is vulnerable; and

(D) Reported parent or caregiver functioning and behavior.

(b) After gathering and documenting the information required in subsection (a) of this section, if the report is about a behavior, condition, or circumstance involving a child-caring agency or proctor foster home, the screener must immediately comply with "Department Responsibilities When a Report of Abuse Involves a Child-Caring Agency or Proctor Foster Home" in OAR 413-015-0620 to 413-015-0640.

(c) Gather information from individuals who can provide firsthand information necessary to determine the appropriate Department response. This may include individuals who have regular contact with the child, doctors, teachers, or others who have evaluated or maintain records on the child, people who are in an established personal or professional relationship with the parent or caregiver and who can judge the quality and nature of the parent or caregiver behavior, and those who have records or reason to know things about the parent or caregiver as a result of their involvement with or exposure to the parent or caregiver.

(d) Research Department history of every identified child, parent, caregiver, and household member for information about current or previous Department involvement relevant to the current child abuse or neglect report. If the research reveals an "unable to locate" disposition that has not

been assessed, the screener must reference that assessment, the date the assessment was completed, and those allegations not able to be assessed in the current report summary.

(e) Inquire regarding possible Indian or Alaskan Native heritage (for further direction see OAR 413-015-0215(5)).

(f) Request relevant information when available and appropriate from law enforcement agencies (LEA), including domestic disturbance calls, arrests, warrants, convictions, restraining orders, probation status, and parole status.

(g) Determine the location and corresponding law enforcement jurisdiction of the family's residence and the site where the alleged child abuse or neglect may have occurred.

(h) Immediately comply with "Department Responsibilities During Screening and Assessment of a Child Abuse or Neglect Report Involving the Home of a Department Certified Foster Parent or Relative Caregiver", OAR 413-200-0404 to 413-200-0424, when information is related to a Department approved and certified home that is a foster home, relative caregiver home, or home of a pre-adoptive family.

(i) Immediately comply with the Child Welfare "Fatality Protocol" when information is related to the death of a child.

(5) Explain to reporters the information in all of the following subsections:

(a) That the Department will not disclose the identity of the reporter unless disclosure is to an LEA for purposes of investigating the report, disclosure is required because the reporter may need to testify as a witness in court, or the court orders the Department to disclose the identity of the reporter.

(b) That anyone making a report of child abuse or neglect in good faith, who has reasonable grounds to make the report, is immune from liability in respect to making the report and the contents of the report.

(c) The Department's decisions about paragraphs (A) through (C) of this subsection. If the decisions have not been made when the report is completed, the screener must notify the reporter that, if contact information is provided, diligent efforts will be made to contact him or her at a later date and inform him or her of the decisions:

(A) Whether contact with the child was made;

(B) Whether the Department determined child abuse occurred; and

(C) Whether services will be provided.

(d) If applicable, that the information reported does not meet the screening criteria to be documented and retained in the Department's electronic information system.

(e) That mandatory reporters should consider maintaining a record of their report to document compliance with mandatory reporting laws.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 418.005 & 419B.020

Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 14-2004, f. 7-30-04, cert. ef. 8-1-04; CWP 4-2005, f. & cert. ef. 2-1-05; CWP 16-2005, f. & cert. ef. 12-1-05; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 22-2007(Temp), f. & cert. ef. 12-3-07 thru 4-11-08; CWP 24-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 4-11-08; CWP 2-2008, f. & cert. ef. 4-1-08; CWP 5-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 12-24-08; CWP 20-2008, f. & cert. ef. 9-2-08; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 27-2015, f. 12-28-15, cert. ef. 1-1-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0210

Determining Department's Response and Required Time Lines for CPS Information

(1) After the screener completes screening activities required by OAR 413-015-0205, and the screener determines the information received is CPS information, the screener must determine the Department response, either CPS assessment required or close at screening. If a CPS assessment is required, the screener must then determine the time line for the Department response, either within 24 hours or within five calendar days.

(2) CPS assessment required. A CPS assessment is required if:

(a) The screener determines that information received constitutes a report of child abuse or neglect, as defined in ORS 419B.005, and the information indicates:

(A) The alleged perpetrator is a legal parent of the alleged child victim;

(B) The alleged perpetrator resides in the alleged child victim's home;

(C) The alleged perpetrator may have access to the alleged child victim, and the parent or caregiver may not be able or willing to protect the child; or

(D) The alleged child abuse occurred in a day care facility, or the home of a Department certified foster parent or relative caregiver.

(b) The screener determines that information received constitutes a report of abuse or neglect as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106, section 36 and the report is the responsibility of the Department as outlined in OAR 413-015-0630.

(c) A tribe or LEA requests assistance from the Department with an investigation of child abuse or neglect, and a CPS supervisor agrees that assistance from the Department is appropriate.

(3) Response Time Lines. If the screener determines that a CPS assessment is required, the screener must:

(a) Determine the CPS assessment response time line. The time line for the Department response refers to the amount of time between when the report is received at screening and when the CPS worker is required to make an initial contact. When determining the response time, the screener must take into account the location of the child, how long the child will be in that location, and access that others have to the child.

(A) Within 24 hours: This response time line is required, unless paragraph (B) of this subsection applies, when the information received constitutes a report of child abuse or neglect as defined in ORS 419B.005 or, when applicable, Oregon Laws 2016, chapter 106, section 36.

(B) Within five calendar days: This response time line must only be used when the screener can clearly document how the information indicates the child's safety will not be compromised by not responding within 24 hours and whether an intentional delay to allow for a planned response is less likely to compromise the safety of the child.

(b) Complete a screening report form immediately when a "within 24 hour" response time line is assigned or the same day when a "within five calendar days" response time is assigned, unless a CPS supervisor grants an extension as provided in OAR 413-015-0220.

(c) Refer the CPS assessment to the appropriate county as described in OAR 413-015-0213.

(4) Close at Screening: A report will be closed at screening if one of the following subsections applies:

(a) The screener determines that information received:

(A) Does not constitute a report of child abuse or neglect, as defined in ORS 419B.005 or, when applicable, Oregon Laws 2016, chapter 106, section 36, and the screener determines:

(i) That the information describes behaviors, conditions, or circumstances that pose a risk to a child; or

(ii) The report includes information involving a child-caring agency or proctor foster home.

(B) Is third party child abuse or neglect that does not require a CPS assessment because the alleged perpetrator does not have access to the child, and the parent or caregiver is willing and able to protect the child; or

(C) Is a report that there are no children in the home and:

(i) An expectant mother is abusing substances during her pregnancy;

(ii) An expectant mother or a household member has had his or her parental rights to another child terminated; or

(iii) An expectant mother or a household member is known to have conditions or circumstances that would endanger a newborn child.

(b) When a report is received, but the screener, after extensive efforts, is unable to obtain sufficient information to locate the child. Name and exact address are not necessary if a location is obtained.

(5) If a report is closed at screening, the screener must:

(a) Document the current information that supports the decision to close the report at screening.

(b) Decide whether other services are appropriate and make service or resource referrals, as necessary. Document what service or resource referrals are made, if any.

(c) Make diligent efforts to contact the reporter if contact information was provided and when the reporter was not informed of the following information prior to completing the screening report form.

(A) Whether contact with the child was made;

(B) Whether the Department determined child abuse occurred; and

(C) Whether services will be provided.

(d) Complete a screening report form no later than the next working day after the screening determination is made, unless a CPS supervisor grants an extension, as provided in OAR 413-015-0220.

Stat. Auth.: ORS 418.005, OL 2016, ch 10

Stats. Implemented: ORS 418.005, OL 2016, ch 10

Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 14-2004, f. 7-30-04, cert. ef. 8-1-04; CWP 4-2005, f. & cert. ef. 2-1-05; CWP 16-2005, f. & cert. ef. 12-1-05; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 25-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-27-08; CWP 7-2008, f. 6-27-08, cert. ef. 6-28-08; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0211

Additional Screening Activities

In the specific circumstances described below, the screener must complete additional activities to complete the screening process.

(1) The screener receives information on an open CPS assessment.

(a) When a screener receives duplicate information (same alleged victim, same alleged perpetrator, same allegation of child abuse or neglect, and same incident dates) on an open CPS assessment, the screener must:

(A) Inform the reporter that a new screening report will not be documented because the information has already been received;

(B) Provide the reporter with the assigned caseworker's name and phone number; and

(C) Provide contact information about the reporter and any information the screener received to the assigned caseworker.

(b) When a screener receives information that constitutes a new report of child abuse or neglect as defined in ORS 419B.005 or, when applicable, Oregon Laws 2016, chapter 106, section 36 on an open CPS assessment, the screener must:

(A) Document the information in a new screening report form; and

(B) Notify the assigned CPS worker and their supervisor of all new information received on the same day the information is received, and document this notification in the Department's electronic information system.

(c) When a screener receives information that constitutes a closed at screening on an open CPS assessment, the screener must:

(A) Document the information in a new screening report form; and

(B) Notify the assigned CPS worker and their supervisor of all new information received on the same day the information is received, and document this notification in the Department's electronic information system.

(2) The screener receives new information on an open Department case.

(a) When a screener receives new information on an open Department case, the screener must:

(A) Consult with a CPS supervisor;

(B) Notify each assigned case worker and their respective supervisors of all new information received on the same day the information is received, and document this notification in the Department's electronic information system's case notes; and

(C) Complete notification on the same day the information is received.

(b) When a screener receives a new report of child abuse or neglect, as defined in ORS 419B.005 or, when applicable, Oregon Laws 2016, chapter 106, section 36, but there is no open CPS assessment, the screener must document the information in a new screening report form.

(c) The information received by a screener on an open Department case that will not be documented in a new screening report form but must be documented in the Department's electronic information system's case notes includes:

(A) Additional information on an open case that does not meet the criteria for a new CPS assessment or closed at screening;

(B) When an in-home protective action plan, initial safety plan, or ongoing safety plan is violated, but the violation is not a new incident of child abuse or neglect;

(C) Reports of an ongoing concern in an open case, which the Department is currently addressing;

(D) Reports of a missing child or young adult; and

(E) Any requests for case information received by the screener.

(3) When a screener receives information related to the home of a Department certified foster parent or relative caregiver, the screener must notify and document that the screener has notified each assigned case worker, assigned certifier, and their respective supervisors of all information received (see "Department Responsibilities During Screening and Assessment of a Child Abuse or Neglect Report Involving the Home of a Department Certified Foster Parent or Relative Caregiver", OAR 413-200-0404 to 413-200-0424).

(4) When a screener receives information related to a minor parent as an alleged perpetrator:

(a) The screener must gather information to determine if there is a report of abuse or neglect with the minor parent as an alleged victim.

(b) If the screener determines there is a report of abuse or neglect of the child of the minor parent with the minor parent as an alleged perpetrator and another report with the minor parent as an alleged victim, the screener must document the information in the following manner to determine when to use the mother or father's name as the case name:

(A) The allegation with the minor parent as an alleged perpetrator must be documented with the mother or father of the alleged victim as the case name (the mother or father being a minor does not preclude them from being the case name); and

(B) The allegation with the minor parent as an alleged victim must be documented with the mother or father of the minor parent as the case name.

(5) When a screener receives a report of a child fatality alleged to be the result of abuse or neglect or involving a child known to the Department, the screener must:

(a) Consult with a CPS supervisor;

(b) Refer to the Child Welfare "Fatality Protocol";

(c) Complete a screening report form identifying in the Department's electronic information system that the report involves a child fatality;

(d) Notify the CPS consultant; and

(e) Complete subsections (a) through (d) of this section even when there are no siblings to the deceased child and no other children in the home where the fatality occurred.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.005, OL 2016, ch 10
Hist.: CWP 16-2005, f. & cert. ef. 12-1-05; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 25-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-27-08; CWP 7-2008, f. 6-27-08, cert. ef. 6-28-08; CWP 15-2009, f. & cert. ef. 11-3-09; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 18-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 3-28-16; CWP 27-2015, f. 12-28-15, cert. ef. 1-1-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0212
Screener Consultation with a CPS Supervisor

Screeners may consult with a CPS supervisor about any screening determination. Screeners must consult with a CPS supervisor or designee in each of the following situations:

(1) A report of child abuse or neglect involving a child, parent, caregiver, or perpetrator who was a child, parent, caregiver, or perpetrator in a CPS assessment that resulted in a founded disposition in the preceding six months.

(2) A review of Department records on a family that is the subject of a child abuse or neglect report finds multiple consecutive reports were closed at screening, and the information received in the current report, in combination with the prior reports regarding the same family, may meet the criteria to refer the report for a CPS assessment.

(3) A new report involving a family that has an open Department case.

(4) A report involving the home of a Department certified foster parent or relative caregiver.

(5) A report involving a child-caring agency or proctor foster home.

(6) A report involving a day care facility.

(7) A report of a child fatality.

(8) A decision not to refer for assessment a report of a baby who is born with substances in his or her system.

(9) A report of child abuse or neglect in which a community partner or an employee of any program, office, or division of the Department of Human Services or the Oregon Youth Authority is the alleged perpetrator.

(10) A report of child abuse or neglect that is expected to receive media attention or that already is being reported by the media.

(11) A decision that an additional screening report form is needed because the reported information alleges a threat of harm to additional children in other families.

(12) A review of Department history reveals a prior allegation that has not been assessed because the Department was unable to locate the family.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.005, OL 2016, ch 10
Hist.: CWP 16-2005, f. & cert. ef. 12-1-05; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 25-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-27-08; CWP 7-2008, f. 6-27-08, cert. ef. 6-28-08; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0215
Notifications and Reports to Specific Agencies or Entities

(1) Law Enforcement Agency (LEA). The screener must cross report to LEA as required by OAR 413-015-0305(1).

(2) Office of Child Care, Department of Education, Early Learning Division. The screener must notify the Office of Child Care when a report involves a day care facility, as required by ORS 419B.020(1). If the report is closed at screening, a copy of the completed screening report form must be sent to the Compliance Unit of the Office of Child Care after information related to the reporter's identity and other confidential information is removed.

(3) Office of Adult Abuse Prevention and Investigation (OAAPI). The screener must report to the OAAPI when a report involves a child with intellectual or developmental disabilities in a 24 hour residential setting licensed by the Office of Developmental Disabilities Services.

(4) Office of Developmental Disabilities Services (ODDS). The screener must notify the ODDS Community Developmental Disabilities Program service coordinator when a report involves a child with intellectual or developmental disabilities in a home certified by the ODDS or the Department.

(5) Indian Tribes. If the screener knows or has reason to know that the child is an Indian child, the screener must give notice within 24 hours to the Indian child's tribe that a CPS assessment is being conducted.

(6) Teacher Standards and Practices Commission (TSPC). The screener must notify the TSPC when a teacher or school administrator, as defined in OAR 413-015-0115, is identified as an alleged perpetrator in a report. A copy of the report must be sent to the TSPC after information related to the reporter's identity and other confidential information is removed.

(7) Community Mental Health Program, Community Developmental Disabilities Program, or Adult Protective Services. The screener must make a report to the Community Mental Health Program, Community Developmental Disabilities Program, or the local Adult Protective Service office when the screener has reasonable cause to believe:

(a) That any person 18 years of age or older with a mental illness, a developmental disability or a physical disability, or any person 65 years of age or older, with whom the screener comes into contact while the screener is acting in an official capacity, has suffered abuse; or

(b) That any person with whom the screener comes into contact, while acting in an official capacity, has abused a person 18 years of age or older with a mental illness, developmental disability, or physical disability, or any person 65 years of age or older.

Stat. Auth.: ORS 418.005 & 419B.017
Stats. Implemented: ORS 418.005, 419B.015 & 419B.017
Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 4-2005, f. & cert. ef. 2-1-05; CWP 16-2005, f. & cert. ef. 12-1-05; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 25-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-27-08; CWP 7-2008, f. 6-27-08, cert. ef. 6-28-08; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 5-2016(Temp), f. & cert. ef. 4-11-16 thru 10-7-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0300
Cross Reporting Defined

The Department and law enforcement agencies are required by ORS 419B.015 to notify each other when a report of child abuse or neglect, as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106, section 36, is received. This process is known as cross reporting, and the notification is called a cross report. OAR 413-015-0300 to 413-015-0310 explain when and how a report of child abuse or neglect received by Child Welfare or a law enforcement agency is cross reported. Information is not cross reported until it is received.

Stat. Auth.: ORS 418.005 & 419B.015
Stats. Implemented: ORS 418.005, 419B.015, 419B.017, 419B.020
Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 18-2005(Temp), f. 12-30-05 cert. ef. 1-1-06 thru 6-30-06; CWP 13-2006, f. 6-30-06, cert. ef. 7-1-06; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0409
Exception to Completing CPS Assessment Activities

(1) The only exception to completing the CPS assessment activities required by these rules (OAR 413-015-0400 to 413-015-0485) on an assigned referral is when a CPS worker, in consultation with a CPS supervisor or designee, determines prior to the initial contact (see OAR 413-015-0420) that the referral does not require a CPS assessment because:

(a) The referral was opened in error; or

(b) There is no longer an allegation of abuse or neglect. The CPS worker received information after being assigned the referral and that information in combination with the corresponding screening report no longer constitutes a report of child abuse or neglect as defined in ORS 419B.005 or, when applicable, Oregon Laws 2016, chapter 106, section 36. This exception may be used only when the CPS worker and the CPS supervisor or designee determine the information:

(A) Is not from the alleged perpetrator;

(B) Relates directly to and specifically negates all allegations in the screening report; and

(C) Is considered on the basis of the objectivity of the individual providing the information and the quality of the information.

(2) The exception in section (1) of this rule is not permitted and a CPS assessment must be completed when the CPS worker has already made contact with the parent, caregiver, or alleged victim, unless the parent, caregiver, or alleged victim is the original reporter.

(3) The CPS worker must document the determination in the Department's electronic information system and explain the basis for the determination that a CPS assessment is not necessary.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 409.185, 418.005, 418.015, 419B.005 - 419B.050
Hist.: CWP 3-2007, f. & cert. ef. 3-20-07; CWP 6-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 12-24-08; CWP 20-2008, f. & cert. ef. 9-2-08; CWP 13-2009, f. 10-1-09, cert. ef. 10-2-09; CWP 13-2009, f. 10-1-09, cert. ef. 10-2-09; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 13-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; CWP 17-2014, f. & cert. ef. 12-24-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0415
CPS Assessment Activities

The required CPS assessment activities are outlined below. The activities are described in a logical order in these rules, but the order in which they occur is controlled by the specific circumstances in a given case.

(1) Review Records.

(a) The assigned CPS worker must:

(A) Thoroughly review the documentation in the referral;

(B) Thoroughly review the paper and electronic records maintained by the Department for historical information on the family and the child that may be useful in completing the CPS assessment;

(C) Thoroughly review available Self-Sufficiency records; and

(D) Make diligent efforts to contact another state's child welfare agency to obtain records, if any, when the CPS worker has information that the family has lived in another state.

(b) The CPS worker must review the documents to identify information related to:

(A) Present danger safety threats or impending danger safety threats;

(B) History or a pattern of abuse or neglect;

(C) Child and family support systems and protective capacity; and

(D) Worker safety.

(2) Addressing Prior Allegations That Have Not Been Assessed Because the Department was Unable to Locate the Family. The assigned CPS worker must address in the current assessment any allegations not previously assessed because the Department was unable to locate the family as follows:

(a) Discuss the prior unassessed allegations during interviews;

(b) Consider all information about prior unassessed allegations when determining child safety; and

(c) Document the consideration of prior unassessed allegations in interviews, observations, and dispositional findings.

(3) Contact Collateral Sources.

(a) The CPS worker must contact collateral sources who can clarify or supplement the information in the referral and in records already reviewed.

(A) The CPS worker must contact the assigned Self-Sufficiency worker, if any.

(B) The CPS worker may contact other collateral sources including, but not limited to:

(i) Individuals who have regular contact with the child;

(ii) Doctors or others who have evaluated or maintain records on the child;

(iii) People who are in an established personal or professional relationship with the parent or caregiver and who can judge the quality and nature of the parent or caregiver behavior and functioning; and

(iv) People who have records or information about the parent or caregiver as a result of their involvement with, or exposure to, the parent or caregiver.

(b) The CPS worker must gather information from collateral sources throughout the CPS assessment.

(c) The CPS worker must:

(A) Protect the identity of collateral sources to the extent possible.

(B) Consult with the district attorney or the assistant attorney general to obtain a court order for records from a collateral source, if the source is unable or unwilling to share information with the Department.

(4) Consult with CPS Supervisor.

(a) The CPS worker must consult with a CPS supervisor or designee:

(A) When the CPS worker has reasonable cause to believe the alleged perpetrator is an employee of any program, office, or division of the Department of Human Services or Oregon Youth Authority (OYA);

(B) When a referral involves the home of a Department certified foster parent or relative caregiver;

(C) When a referral involves allegations that child abuse or neglect occurred in a child-caring agency or proctor foster home;

(D) When a CPS worker receives notification from a screener that a closed at screening or new referral was created on an open CPS assessment;

(E) Prior to a decision to place a child in protective custody, or after placement if consultation before placement will delay the safety intervention;

(F) Prior to initiating court action, or after initiating court action if consultation before will delay the safety intervention;

(G) Prior to developing an initial safety plan with a Department certified foster parent or relative caregiver;

(H) When the referral involves a child fatality;

(I) When making a disposition in a complicated or sensitive situation or case; or

(J) When closing an assessment with the disposition of "unable to locate".

(b) Subject to the discretion of the CPS supervisor, the CPS worker will consult with a CPS supervisor or designee at additional key points during the assessment, such as:

(A) Before making initial contact with the family; or

(B) When a referral indicates potential danger to the worker.

(5) Contact and Work with Other Entities. The CPS worker may need to work with representatives of other entities to gather and analyze safety-related information, develop a sufficient protective action plan, initial safety plan, or ongoing safety plan, and to complete the CPS assessment.

(a) The CPS worker may, as appropriate, notify or consult with other Department of Human Services programs or other agencies, including but not limited to the Office of Vocational Rehabilitation Services and Animal Control.

(b) The CPS worker must report to or contact and work with other entities as follows:

(A) Office of Child Care. The CPS worker must notify and coordinate with the Compliance Unit of the Office of Child Care when a report involves a registered day-care home or a licensed day-care center, as required by ORS 419B.020(1).

(B) Oregon Youth Authority (OYA). The CPS worker must notify OYA when the allegation involves an OYA certified foster home.

(C) Office of Adult Abuse Prevention and Investigation (OAAPI). The CPS worker must notify the OAAPI when an allegation involves a child with intellectual or developmental disabilities in a 24 hour residential setting licensed by the Office of Developmental Disabilities Services.

(D) Office of Developmental Disabilities Services (ODDS). The CPS worker must notify the ODDS Community Developmental Disabilities Program service coordinator when a report involves a child with intellectual or developmental disabilities in a home certified by the ODDS or the Department.

(E) Community Mental Health Program, Community Developmental Disabilities Program, or Adult Protective Services. The CPS worker must make a report to the Community Mental Health Program, Community Developmental Disabilities Program, or the local Adult Protective Service office when the CPS worker has reasonable cause to believe:

(i) That any person 18 years of age or older with a mental illness, a developmental disability or a physical disability, or any person 65 years of age or older, with whom the CPS worker comes into contact while acting in an official capacity, has suffered abuse.

(ii) That any person with whom the CPS worker comes into contact, while acting in an official capacity, has abused a person 18 years of age or older with a mental illness, a developmental disability or a physical disability, or any person 65 years of age or older.

(F) Indian Tribes. If the CPS worker knows or has reason to know that the child is an Indian child, the CPS worker must give notice within 24 hours to the Indian child's tribe that a CPS assessment is being conducted unless the screener documented completion of this notification in the referral.

(G) Probation and Parole. The CPS worker must contact probation and parole when the allegation involves a parent or caregiver, or alleged perpetrator who is supervised by probation or parole.

(H) Law Enforcement. If the screener did not cross report, the CPS worker must contact one or more law enforcement agencies (LEA) in accordance with the protocols of the local MDT agreement and in accordance with cross reporting rules, OAR 413-015-0300 to OAR 413-015-0310. When there is a joint response involving a CPS worker and LEA staff, the CPS worker is still responsible for all of the activities necessary to complete a CPS assessment which are summarized in OAR 413-015-0400. The CPS worker must, in consultation with a CPS supervisor, determine whether to coordinate assessment activities with LEA in the following situations:

(i) Presence of danger. When the CPS worker has information that indicates that the child is unsafe right now.

(ii) Family cooperation. When the CPS worker has information that the family may not allow the CPS worker to observe the alleged victim or other children in the home.

(iii) Protective custody. When the CPS worker has information that a child may need to be placed in protective custody for the child's safety.

(iv) Child interview. When the CPS worker and the LEA officer must each interview a child, it is preferable to coordinate the interviews to reduce the number of interactions with the child.

(v) Worker safety. When the CPS worker has information that indicates the family behaviors, conditions, or circumstances could pose a danger to the CPS worker.

(vi) Crime committed. When the CPS worker suspects or receives a report that a crime may have been committed.

(I) Public or Private Schools. The CPS worker may interview a child at school when the worker believes it will be the best environment in which to assure a child's safety when making contact with the child. ORS 419B.045 provides requirements for CPS investigations that are conducted on school premises. The CPS worker must do following:

(i) Notify the school administrator that a CPS assessment must be conducted. If the school administrator is a subject of the CPS assessment, then notification is not required.

(ii) Report to the school office, provide identification, inform school personnel of the CPS assessment, and provide the name of the child to be interviewed.

(iii) Request information from school personnel regarding the disabilities of the child, if any, prior to an interview with the affected child.

(iv) Interview the child out of the presence of other persons, unless the CPS worker believes the presence of a school employee or other person would facilitate the interview. If the CPS worker believes that a school employee does not need to be present, but the school employee insists on being present during the interview, the worker may confer with the CPS supervisor for assistance in handling the situation.

(v) Discuss further actions with the child at the conclusion of the interview.

(vi) Inform school personnel when the interview has been completed.

(vii) Inform school personnel if the child is taken into protective custody.

(viii) Inform school personnel that the CPS worker will notify parents of the interview.

(ix) Contact the CPS supervisor if school officials refuse to allow the assessment to take place on school property.

(J) Multi-Disciplinary Teams (MDTs). Department district managers must develop interagency agreements regarding assessment of child abuse and neglect, as necessary, with local MDTs. Requirements for MDT protocols are set out in ORS 418.747.

(6) Obtain Interpreters and Translation. The CPS worker must obtain the services of a competent interpreter and competent written translation service for families, including hearing-impaired family members, who have limited or no means of communicating in or reading English.

(7) Determine Indian Child Welfare Act (ICWA) Status and Comply with ICWA, if Applicable. The CPS worker must initiate the process to determine the child's ICWA status and notify the Indian child's tribe if ICWA applies. To initiate this process, the CPS worker must:

(a) Assure completion of a form CF 1270, "Verification of ICWA Eligibility", to assist in determining ICWA eligibility.

(b) Contact the child's tribe when an Indian child is the subject of a CPS assessment. Federally recognized tribes must be notified within 24 hours after information alleging abuse or neglect is received by the Department.

(c) If the Indian child is enrolled or eligible for enrollment in a federally recognized tribe, notify the child's tribe if the child may be placed in protective custody.

(d) Consult with the local Department ICWA liaison, a supervisor, or the ICWA manager if the worker has questions regarding the involvement of a tribe or the ICWA status of a child.

(e) Make a diligent attempt to address the following when determining the placement resource:

(A) Contact the tribe's social services department;

(B) Search for relative resources;

(C) Search for available Indian homes; and

(D) Contact other Indian tribes and other Indian organizations with available placement resources.

(f) Unless the Indian child's tribe has established a different order of preference, comply with the ICWA placement preference, which is:

(A) Placement with a member of Indian child's extended family.

(B) Placement with a foster family that is licensed, approved or specified by the Indian child's tribe.

(C) Placement with an Indian foster home licensed or approved by an authorized non-Indian licensing authority.

(D) Placement with an institution for children approved by an Indian tribe or operated by an Indian organization which has a program suitable to meet the Indian child's needs.

(8) Determine Refugee Status and Comply with the Refugee Children Act, if applicable. During a CPS assessment, the CPS worker must consider whether the child is a refugee child. Under ORS 418.925, a "refugee child" is a "person under 18 years of age who has entered the United States and is unwilling or unable to return to the person's country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular group or political opinion, or whose parents entered the United States within the preceding 10 years and are or were unwilling or unable to return to their country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular group or political opinion."

(a) If it appears that a child is a refugee child, the CPS worker must ask about the child or parents' country of origin, length of time the child or parents have been in the United States, reasons why the child or parents came to the United States, and ethnic and cultural information relevant to the child's status as a refugee. The CPS worker does not have to make a legal determination that the child and parent are refugees, but if the child or the parents indicate they are refugees, then the CPS worker must proceed as if they are, until or unless it is known that they are not refugees.

(b) The CPS worker may not take a refugee child into protective custody unless, in addition to the other requirements for taking a child into custody, the CPS worker determines that:

(A) Removal is necessary to prevent imminent serious emotional or physical harm to the child; and

(B) Reasonable efforts to alleviate the harm through remedial or preventive services do not alleviate the harm, have failed, or are not practical in an emergency situation.

(c) Unless it is a voluntary placement, no refugee child may remain in placement more than five days unless there has been a judicial determination, supported by clear and convincing evidence that:

(A) Preventative or remedial services provided by the Department have failed to alleviate the need for removal; and

(B) Return to the home will likely result in psychological or physical damage to the child.

(d) When a refugee child is placed in care, the juvenile court petition must include, in addition to the information required by ORS 419B.809, the following information:

(A) A specific and detailed account of the circumstances that led the Department to conclude that the child was in imminent danger of serious emotional or physical harm;

(B) Specific actions the Department has taken or is taking to alleviate the need for removal;

(C) Assurance that the Department has complied with placement preferences listed in ORS 418.937 and listed in subsection (e) of this section; and

(D) Assurance that the Department is making or has made diligent efforts to locate and give notice to all affected refugee family members and to the Refugee Child Welfare Advisory Committee that the petition has been filed.

(e) The CPS worker must consider the refugee child's culture and tradition when making any placement decision for a refugee child and, unless shown to be inappropriate and inconsistent with the best interests of the child, place the child with the following in order of preference:

(A) Natural parents.

(B) Extended family member.

(C) Members from the same cultural heritage.

(D) Persons with knowledge and appreciation of the child's cultural heritage.

(f) The CPS worker may determine that placement under subsection (e) of this section is inappropriate and inconsistent with the best interests of the child if:

(A) The preferred placement presents a threat to the child's safety;

(B) The extreme medical, physical, or psychological needs of the child cannot be met in the placement; or

(C) There is an informed request from either of the child's biological parents not to use a placement, if the request is consistent with stability, security, and the individual needs of the child.

(g) When a juvenile court petition is filed and a refugee child is placed in care, the CPS worker must staff the case with the Refugee Child Welfare Advisory Committee (RCWAC). The CPS worker must contact the International Case Consultant for the Department to arrange a time for the staffing. In preparation for the staffing, the CPS worker must:

(A) Invite the CPS supervisor to the staffing; and

(B) Be prepared to discuss the reasons for the CPS referral, the information indicating that family members are refugees, and their country of origin.

(9) Take Photographs. The CPS worker must, during the CPS assessment, take photographs and document, as necessary, child abuse or neglect and the observable nature of any present danger safety threat or impending danger safety threat.

(a) As provided in ORS 419B.028, a law enforcement officer or the CPS worker may take photographs for the purpose of documenting the child's condition at the time of the CPS assessment.

(b) As provided in ORS 419B.028, if the CPS worker conducting a CPS assessment observes a child who has suffered suspicious physical injury and the CPS worker is certain or has a reasonable suspicion that the injury is or may be the result of abuse, the CPS worker, in accordance with the protocols and procedures of the county multi-disciplinary team described in ORS 418.747, will immediately photograph or cause to have photographed the suspicious physical injuries. Regardless of whether the child has previously been photographed or assessed during a CPS assessment, the CPS worker will photograph or cause to be photographed any suspicious injuries if the CPS worker is certain or has a reasonable suspicion the suspicious injuries are the result of abuse:

(A) During the assessment of a new allegation of abuse; and

(B) Each time, during the assessment, an injury is observed that was not previously observed by the assigned CPS worker.

(c) When a child is photographed pursuant to subsection (b) of this section:

(A) The person taking the photographs or causing to have the photographs taken must, within 48 hours or by the end of the next regular business day, whichever occurs later:

(i) Provide hard copies or prints of the photographs and, if available, copies of the photographs in an electronic format to the designated medical professional; and

(ii) Place hard copies or prints of the photographs and, if available, copies of the photographs in an electronic format in the Department record labeled with the case name, case number, child's name, and date taken.

(B) If a county multidisciplinary team staffing of the case is held, photographs of the injury will be made available to each team member involved in the case staffing at the first meeting regarding the child's case.

(d) The CPS worker must document injuries, hazardous environments, and the observable nature of any present danger safety threat or impending danger safety threat in the assessment narrative by use of photographs, written description, or illustrations.

(e) Photographs of the anal or genital region may be taken only by medical personnel.

(10) Obtain Medical Assessment. The CPS worker must, during the CPS assessment as required in this section, facilitate a medical assessment of the child and obtain the child's medical history when necessary to assure child safety, determine treatment needs, reassure the child and family, or assist in analyzing safety-related information.

(a) When the CPS worker determines that the child is in need of a medical assessment as part of a CPS assessment, the CPS worker must consult with a CPS supervisor as soon as possible, but not at the expense of delaying medical treatment.

(b) If a person conducting an assessment under ORS 419B.020 observes a child who has suffered suspicious physical injury as defined in ORS 419B.023 and the person is certain or has a reasonable suspicion that the injury is or may be the result of abuse, the person must, in accordance with the protocols and procedures of the county multi-disciplinary team described in ORS 418.747, ensure that;

(A) A designated medical professional conducts a medical assessment within 48 hours of the observation of the suspicious physical injury, or sooner if dictated by the child's medical needs; or

(B) An available physician, physician assistant, or nurse practitioner conducts a medical assessment if, after reasonable efforts to locate a designated medical professional, a designated medical professional is not available to conduct a medical assessment within 48 hours. The CPS worker is required to document in the Department's electronic information system efforts to locate the designated medical professional when an available physician, physician assistant, or nurse practitioner is used.

(c) The CPS worker must facilitate an assessment by a medical professional if the alleged child abuse or neglect involves injury to the anal or genital region.

(d) When there are indications of severe physical trauma to the child, the CPS worker must make arrangements to immediately transport the child to a medical facility, which may include calling 911. The CPS worker must

also make arrangements for medical examination of a child for mild or moderate physical trauma.

(e) To make arrangements for the medical examination of a child, the CPS worker must do the following, unless completing the action would delay medical treatment for the child:

(A) Discuss with the parent or caregiver the need for medical examination or treatment.

(B) Ask the parent or caregiver to take the child to a medical facility for a medical examination or treatment.

(C) Request that the parent sign a form DHS 2099, "Authorization for Use and Disclosure of Information".

(D) Contact an LEA immediately and seek a juvenile court order to obtain protective custody of the child for the purpose of obtaining a medical examination or treatment when:

(i) The parent or caregiver refuses to obtain needed medical examination or treatment;

(ii) The parent or caregiver may flee with the child; or

(iii) Delaying medical examination or treatment could result in severe harm to the child.

(E) Immediately seek medical care and consultation when the child may have a life-threatening condition, or a deteriorating condition that may become life-threatening.

(F) As soon as possible and not later than 24 hours after learning of the exposure, make arrangements to have the child tested for chemical exposure to harmful substances when there is reason to believe a child has been exposed to dangerous chemicals such as those found in a chemical drug lab.

(f) When a report of suspected medical neglect of an infant with a disability and with life-threatening conditions is referred for CPS assessment, the assigned CPS worker must comply with "Investigation of Suspected Medical Neglect-Infants", OAR 413-030-0600 to 413-030-0650.

(g) When it is medically indicated to subject a child in the custody of the Department to HIV testing, the CPS worker must comply with "HIV Testing of Children in Custody and HIV Confidentiality", OAR 413-040-0400 to 413-040-0450.

(h) As provided in ORS 147.425, a child who is the victim of a person crime and is at least 15 years of age at the time of the abuse may have a personal representative present during a medical examination. If a CPS worker believes that a personal representative would compromise the CPS assessment, a CPS worker may prohibit a personal representative from being present during the medical examination.

(i) When the CPS worker is assessing a CPS allegation of medical neglect, the CPS worker must consult with a health care professional as part of the assessment.

(11) Obtain Psychological and Psychiatric Evaluations.

(a) The CPS worker must make a referral for a psychological or psychiatric evaluation of the parent, caregiver, or child by a mental health professional to assure child safety, determine treatment needs, or assist in analyzing safety-related information when during the CPS assessment the CPS worker identifies a specific condition or behavior that requires additional professional evaluation. This includes but is not limited to:

(A) Unusual or bizarre forms of punishment;

(B) Mental illness;

(C) Suicidal ideation;

(D) Homicidal ideation; or

(E) Unusual or bizarre child or parental behavior that is indicative of emotional problems.

(b) The CPS worker must obtain consent of the parent or caregiver prior to making a referral for a psychological or psychiatric evaluation of the parent, caregiver, or child, unless the evaluation is court ordered.

(12) Make Monthly Face-to-Face Contact. The CPS worker must make a minimum of monthly face-to-face contact as described in OAR 413-080-0054.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 409.185, 418.005, 418.015, 418.747, 418.785 & 419B.005 - 419B.050

Hist.: CWP 3-2007, f. & cert. ef. 3-20-07; CWP 16-2007(Temp), f. & cert. ef. 10-16-07 thru 4-11-08; CWP 24-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 4-11-08; CWP 2-2008, f. & cert. ef. 4-1-08; CWP 6-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 12-24-08; CWP 20-2008, f. & cert. ef. 9-2-08; CWP 23-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; CWP 4-2010, f. & cert. ef. 4-2-10; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 13-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; CWP 17-2014, f. & cert. ef. 12-24-14; CWP 18-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 3-28-16; CWP 27-2015, f. 12-28-15, cert. ef. 1-1-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0420

Make Initial Contact

(1) The CPS worker must make an initial contact within the assigned response time line.

(2) The following outlines contacts the CPS worker is required to attempt and, when possible, complete at initial contact. The CPS worker must:

(a) Have face-to-face contact with and interview the alleged victim, his or her siblings, and other children living in the home except as provided in OAR 413-015-0640. The purpose of the face-to-face contact and interview with the alleged victim, his or her siblings, and other children living in the home is to gather information regarding possible child abuse and neglect, gather information about the children's functioning and vulnerability, and assess the children's immediate safety.

(A) Interview and observe children as follows:

(i) The CPS worker must notify parents of the intent to interview a child, unless notification could compromise the child's safety.

(ii) The CPS worker must make diligent efforts to contact the child at home, school, day care, or any other place where the worker believes the child may be found. If the CPS worker is unsuccessful, the CPS worker must document in the Department's electronic information system all attempts made to contact the child and the dates of those attempted contacts.

(iii) When the CPS worker contacts the child at home and the parent or caregiver is not present:

(I) The CPS worker must consult with a CPS supervisor and seek assistance from LEA if the referral indicates there is reasonable cause to believe the child's health or safety is endangered by the conditions of the dwelling; or the child is inadequately supervised and there is an immediate need to evaluate the child's health and safety.

(II) The CPS worker must wait until the parent is present in the home to complete a child interview in the home if there is not reasonable cause to believe the child's health or safety is endangered by the conditions of the dwelling or that the child is inadequately supervised.

(iv) When the CPS worker is denied access to the child or to the child's residence, the CPS worker must, if the referral indicates that the child may be unsafe, request assistance from LEA in assessing the situation and in taking the child into protective custody if needed. If the referral indicates that the child is presently safe, the CPS worker must consider the following:

(I) Attempting to contact other persons who may have relevant information regarding the referral;

(II) Persisting in attempts to gain cooperation from the family or caregivers, depending on the known child safety information;

(III) Seeking LEA assistance;

(IV) Consulting with the CPS supervisor, the district attorney, assistant attorney general, or the county juvenile department to discuss possible juvenile court action; or

(V) Seeking a protective custody order from the juvenile court.

(v) The CPS worker must conduct interviews in a manner that assures privacy for the child.

(vi) If the parent or caregiver is the alleged perpetrator or if the presence of the parent or caregiver might impede the interview, the CPS worker must attempt to interview children outside the presence of their parents or caregivers.

(vii) A CPS worker must allow a child who is the victim of a person crime as defined in ORS 147.425 and is at least 15 years of age at the time of the abuse to have a personal representative be present during an interview. If a CPS worker believes that the personal representative would compromise the CPS assessment, the CPS worker may prohibit a personal representative from being present during the interview.

(viii) The CPS worker must observe the child's injuries or signs of neglect. The CPS worker may need to remove a child's clothing to make adequate observations. In that event, the CPS worker must:

(I) Use discretion and make the child as comfortable as possible.

(II) Seek parental consent and assistance, when possible and appropriate.

(III) Consider requesting a worker or other support person, who is the same gender as the child, be present to serve as a witness and provide comfort for the child.

(ix) The CPS worker may observe injuries to a child's anal or genital region if the child is not school aged and if the injury can be observed without the CPS worker touching the child's anal or genital region.

(B) The CPS worker must notify the parents or caregivers the same day a child is interviewed. If the same day notification could make a child

or adult unsafe, a CPS supervisor may authorize an extension for one day to allow a planned notification that is less likely to compromise safety. The CPS worker must document in the Department's electronic information system the supervisory approval and an explanation describing the basis for the approval.

(b) Have face-to-face contact with and interview the non-offending parent or caregiver and all adults living in the home except as provided in OAR 413-015-0640. The purpose of this face-to-face contact and interview is to find out what the non-offending parent or caregiver and other adults living in the home know about the alleged child abuse or neglect, gather information related to the safety of the child, including parent and caregiver functioning, and gather information to determine if the parent or caregiver can or cannot and will or will not protect the child.

(A) Whenever practicable, the CPS worker must interview both parents and caregivers in person, as follows:

(i) Interview each person in a manner that considers each person's privacy and safety and assures effective communication. This may require interviewing parents or caregivers individually and also together depending on the information being gathered;

(ii) Ask questions about domestic violence in separate interviews only; and

(iii) Provide all adults living in the home with a written notice that a criminal records check may be conducted on them.

(B) The CPS worker must provide each parent or caregiver with a "What you need to know about a Child Protective Services assessment" pamphlet, which includes written information regarding the CPS assessment process, including the court process and the rights of the parent and caregiver.

(C) The CPS worker must interview the non-custodial legal parent during the CPS assessment. This is not required during the initial contact, but must be completed as part of the assessment process because the non-custodial parent may have essential information or be a placement resource. If the interview of the non-custodial legal parent may make a child or adult unsafe, a CPS supervisor may authorize an exception to this requirement based on written documentation that supports the conclusion that an interview with a non-custodial legal parent should not be conducted.

(c) Have face-to-face contact with and interview the alleged perpetrator. Except as provided in this subsection, the CPS worker must make face-to-face contact with and interview the alleged perpetrator during the initial contact when he or she is the child's custodial parent, caregiver, any person living in the home, or is present in the home when the CPS worker makes contact. The purpose of this interview is to evaluate the alleged perpetrator's reaction to allegations of abuse or neglect as well as to the child and his or her condition, and to gather further information about the alleged perpetrator and the family in relation to the safety of the child. When the alleged perpetrator is a minor parent, the purpose is also to determine if the minor parent is an alleged victim of abuse (under paragraph (D) of this subsection).

(A) The CPS worker is not required to make face-to-face contact with or interview the alleged perpetrator during the initial contact if:

(i) The alleged perpetrator is not a custodial parent, caregiver, anyone living in the home, or is not present in the home when the CPS worker makes contact and delaying contact will not compromise child safety. The CPS worker still must interview the alleged perpetrator, but may complete the interview during the course of the CPS assessment; or

(ii) There is a criminal investigation and the interview cannot be coordinated with an LEA within the time lines for initial contact.

(B) The decision to delay interview of an alleged perpetrator as provided in subparagraphs (A)(i) or (ii) of this subsection must be approved by a CPS supervisor, and the CPS worker must document in the Department's electronic information system both the approval and the reason for delaying the interview.

(C) When interviewing the alleged perpetrator, the CPS worker must:

(i) Coordinate the interviews of the alleged perpetrator with LEA when law enforcement is conducting an investigation;

(ii) Consult with a CPS supervisor if an interview with the alleged perpetrator could make a child or adult unsafe;

(iii) Provide the alleged perpetrator with a written notice that a criminal records check may be conducted on them; and

(iv) Make inquiries about the employment status of the alleged perpetrator. If the CPS worker has reasonable cause to believe the alleged perpetrator is an employee of any program, office, or division of the Department of Human Services (DHS) or OYA, the CPS worker must notify a CPS supervisor. The CPS supervisor must confirm the person's employee status by contacting a Central Office Field Services representative. If the CPS supervisor determines the alleged perpetrator is an employee of the DHS or OYA, the CPS supervisor must notify the DHS Office of Human Resources at the time of the assessment and at the time the assessment is reviewed as required in OAR 413-015-0475. The CPS supervisor must document the notifications in the Department's electronic information system.

(D) When interviewing the alleged perpetrator who is a minor and the parent of the alleged victim, the CPS worker must ask questions to determine if there is an allegation of abuse or neglect with the minor parent as an alleged victim. If it is determined that there is an allegation of abuse or neglect with the minor parent as an alleged victim, the information must be reported to a screener.

(E) When interviewing an alleged perpetrator who is the parent or caregiver, the CPS worker must provide the parent or caregiver with a "What you need to know about a Child Protective Services assessment" pamphlet, which includes written information regarding the CPS assessment process, including the court process and the rights of the parent and caregiver.

(3) Gather safety-related information through interviews and observation. The CPS worker must begin to gather safety-related information through interviews and observation as outlined in OAR 413-015-0422, "Gather Safety Related Information through Interview and Observation".

(4) Determine if there is a present danger safety threat or impending danger safety threat. During the initial contact, the CPS worker must determine, based on the information obtained at that time, if there is a present danger safety threat or impending danger safety threat to the child as outlined in OAR 413-015-0425, "Determine if there is a Present Danger Safety Threat or Impending Danger Safety Threat".

(5) Documentation of the Initial Contact. The CPS worker must document the dates of attempted and successful contacts in the Department's electronic information system. If it was not possible during the initial contact for the CPS worker to successfully complete a required contact, the CPS worker must document why contact was not made and must complete the face-to-face contact and interview as soon as possible.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 147.425, 409.185, 418.005, 418.015, 418.747, 418.785, 419B.005 - 419B.050
Hist.: CWP 3-2007, f. & cert. ef. 3-20-07; CWP 16-2007(Temp), f. & cert. ef. 10-16-07 thru 4-11-08; CWP 2-2008, f. & cert. ef. 4-1-08; CWP 15-2009, f. & cert. ef. 11-3-09; CWP 2-2010(Temp), f. & cert. ef. 2-12-10 thru 8-11-10; CWP 4-2010, f. & cert. ef. 4-2-10; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 13-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; CWP 17-2014, f. & cert. ef. 12-24-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0440
Determine Disposition of the CPS Assessment

(1) After gathering all the information necessary to complete the CPS assessment, the CPS worker must determine the disposition.

(2) Requirement to Determine Disposition of the CPS Assessment. The CPS worker must determine if there is reasonable cause to believe that child abuse or neglect occurred and explain the basis for that determination.

(a) The requirements for determining dispositions on a report of abuse or neglect as defined in ORS 419B.005 are described in OAR 413-015-1000, "The CPS Assessment Dispositions".

(b) The requirements for determining dispositions on a report of abuse or neglect involving a child-caring agency or proctor foster home as defined in Oregon Laws 2016, chapter 106, section 36 are described in OAR 413-015-0620 to 413-015-0640.

(3) When a disposition is founded for child abuse or neglect, the CPS worker must refer all victims three years old and under to Early Intervention. In completing the referral, the CPS worker must use the "CPS to Early Intervention Referral Form" (DHS 323) when a release of information is not signed.

(4) Documentation. The CPS worker must document that determination and explain the basis for the determination in the disposition narrative section of the Department's electronic information system prior to completing the CPS assessment.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 409.185, 418.005, 418.015, 419B.005 - 419B.050
Hist.: CWP 3-2007, f. & cert. ef. 3-20-07; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0445
Make Child Safety Decision and Determine Whether to Open a Case

(1) After all the necessary information is gathered for the CPS assessment and the disposition has been determined, the CPS worker must determine if the child is safe or unsafe at the conclusion of the CPS assessment. To make a child safety decision at the conclusion of a CPS assessment, the CPS worker must again determine if an impending danger safety threat is

present as outlined in OAR 413-015-0425, "Determine if there is a Present Danger Safety Threat or Impending Danger Safety Threat".

(2) When at the conclusion of the CPS assessment the CPS worker determines one or more impending danger safety threats are present, including a previously identified threat that has not been eliminated, the CPS worker must conclude the child is unsafe. When the CPS worker concludes the child is unsafe at the conclusion of the CPS assessment, the CPS worker must:

(a) Determine how the impending danger safety threat is occurring to support the development of an ongoing safety plan as outlined in OAR 413-015-0428, "Identify How the Impending Danger Safety Threat is Occurring";

(b) Develop an ongoing safety plan as outlined in OAR 413-015-0450, "Develop Safety Plans";

(c) Complete the CPS assessment; and

(d) Open a case.

(3) When at the conclusion of the CPS assessment the CPS worker determines no impending danger safety threats are present and any threat identified previously has been eliminated, the CPS worker must conclude the child is safe. When the CPS worker concludes the child is safe at the conclusion of the CPS assessment, the CPS worker must comply with all of the following subsections:

(a) Dismiss the protective action plan or initial safety plan if one is in place.

(b) Determine if the family has moderate to high needs unless completing a CPS assessment involving the home of a Department certified foster parent or relative caregiver, a child-caring agency, or a proctor foster home.

(A) If the family does not have moderate to high needs the CPS worker must complete and close the CPS assessment.

(B) If the family does have moderate to high needs the CPS worker must:

(i) Offer the family referrals to relevant non-contracted community services as available; and

(ii) If the family accepts the offer for referrals to non-contracted community services, the CPS worker must refer the family to relevant non-contracted community services as available.

(c) Complete the CPS assessment.

(d) Close the CPS assessment without opening a case.

(4) Documentation of the Child Safety Decision. The CPS worker must document in the Department's electronic information system the child safety decision including all of the following subsections as applicable:

(a) If the child is safe and the assessment will be closed or the child is unsafe and the case will be opened.

(b) If the child is safe:

(A) Whether the family was identified as having moderate to high needs; and

(B) If applicable, whether the family accepted the offer for non-contracted community service referrals.

(c) The basis for the determination in subsection (a) of this section.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 409.185, 418.005, 418.015, 419B.005 - 419B.050
Hist.: CWP 3-2007, f. & cert. ef. 3-20-07; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0450
Develop an Ongoing Safety Plan

(1) At the completion of the CPS assessment when the CPS worker determines, through an analysis of the safety-related information, that a child is unsafe, the CPS worker must develop and document an ongoing safety plan unless completing a CPS assessment involving the home of a Department certified foster parent or relative caregiver, a child- caring agency, or a proctor foster home. The purpose of the ongoing safety plan is to control the impending danger safety threats as they are uniquely occurring within a particular family.

(2) Requirements for an Ongoing Safety Plan. When developing an ongoing safety plan the CPS worker must assure all requirements in OAR 413-015-0432, "Develop Safety Plans", are met and:

(a) Use a Child Safety Meeting unless a supervisor approved an exception;

(b) Include conditions for return when an out-of-home ongoing safety plan is developed; and

(c) Re-evaluate the initial safety plan, if one is in place, to determine if it is appropriate and sufficient as an ongoing safety plan and re-confirm all commitments with all safety service providers identified in the initial safety plan if it is to become an ongoing safety plan.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 409.185, 418.005, 418.015, 419B.005 - 419B.050
Hist.: CWP 3-2007, f. & cert. ef. 3-20-07; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 17-2014, f. & cert. ef. 12-24-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0470
Notifications

(1) Requirements for Providing Notifications. The CPS worker must:

(a) Unless the Department determines that disclosure is not permitted under ORS 419B.035, notify the reporter, if the reporter provided the Department with contact information, whether contact was made, whether the Department determined that child abuse or neglect occurred, and whether services will be provided.

(b) Provide the child's parents, including a non-custodial legal parent, and caregivers verbal notification of all CPS assessment dispositions (unfounded, unable to determine, or founded) and whether the Department will provide services as a result of the CPS assessment. When the child's parent is the perpetrator, the notice under subsection (c) of this section also must be provided. If notification may make a child or adult unsafe, a CPS supervisor may authorize an exception to the requirement to provide notification based on documentation supporting that conclusion.

(c) Provide perpetrators written notification of founded or substantiated dispositions. This written notification must include information about the founded or substantiated disposition review process as outlined in "Notice and Review of CPS Founded Dispositions", OAR 413-010-0700 to 413-010-0750. If the notification could make a child or adult unsafe, a CPS supervisor may authorize an exception to the requirement to provide notification based on documentation that supports this conclusion.

(d) Provide the Teacher Standards and Practices Commission (TSPC) notification of a completed assessment by providing TSPC with a copy of the completed CPS assessment when a teacher or school administrator, as defined in OAR 413-015-0115, is identified as an alleged perpetrator in a report. Regardless of a disposition, a copy of the report must be sent to TSPC after information related to the reporter's identity and other confidential information is removed.

(2) Documentation of Notifications. The CPS worker must document the notifications as described in this rule in the Department's electronic information system and the documentation must include:

(a) Who made the notification.

(b) To whom the notification was made.

(c) The date the notification was made.

(d) That the notifications have been attempted or made within the following time lines:

(A) Prior to completing the CPS assessment for a notification provided under subsection (1)(a) of this rule.

(B) Within five business days of supervisory approval of the CPS assessment for a notification provided under subsection (1)(b) through (1)(d) of this rule.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 409.185, 418.005, 418.015, 419B.005 - 419B.050
Hist.: CWP 3-2007, f. & cert. ef. 3-20-07; CWP 8-2009, f. 7-29-09, cert. ef. 8-3-09; CWP 1-2012(Temp), f. & cert. ef. 3-12-12 thru 9-8-12; CWP 5-2012, f. & cert. ef. 9-7-12; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 27-2015, f. 12-28-15, cert. ef. 1-1-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0620
Purpose

The purpose of OAR 413-015-0000 to 413-015-0000 is to describe Department responsibilities during screening and assessment when a report involves a child-caring agency or proctor foster home.

Stat. Auth.: OL 2016, ch 10
Stats. Implemented: OL 2016, ch 10
Hist.: CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0625
Definitions

The following definitions apply to OAR 413-015-0620 to 413-015-0640:

(1) "Abuse" has the meaning given in ORS 419B.005 and also means one or more of the following (as described in Oregon Laws 2016, chapter 106, section 36):

(a) Any physical injury to a child in care cause by other than accidental means, or which appears to be at variance with the explanation given of the injury.

(b) Neglect of a child in care.

(c) Abandonment, including desertion or willful forsaking of a child in care or the withdrawal or neglect of duties and obligations owed a child in care by a child-caring agency, caretaker, or other person.

(d) Willful infliction of physical pain or injury upon a child in care.

(e) An act that constitutes a crime under ORS 163.375, 163.405, 163.411, 163.415, 163.425, 163.427, 163.467, or 163.525.

(f) Verbal abuse.

(g) Financial Exploitation.

(h) Sexual abuse.

(i) Involuntary seclusion of a child in care for the convenience or a child-caring agency or caretaker or to discipline the child in care.

(j) A wrongful use of a physical or chemical restraint of a child in care, excluding an act of restraint prescribed by a physical licensed under ORS Chapter 677 and any treatment activities that are consistent with an approved treatment plan or in connection with a court order.

(2) "Child in care" means a person under 21 years of age who is residing in or receiving care or services from a child-caring agency or proctor foster home subject to ORS 418.205 to 418.327, 418.475 or 418.950 to 418.970.

(3) "Financial exploitation" means: Wrongfully taking the assets, funds, or property belonging to or intended for the use of a child in care.

(b) Alarming a child in care by conveying a threat to wrongfully take or appropriate moneys or property of the child in care if the child would reasonably believe that the threat conveyed would be carried out.

(c) Misappropriating, misusing or transferring without authorization any moneys from any account held jointly or singly by a child in care.

(d) Failing to use the income or assets of a child in care effectively for the support and maintenance of the child in care.

(e) "Financial exploitation" does not include age-appropriate discipline that may involve the threat to withhold, or the withholding of, privileges.

(4) "Intimidation" means compelling or deterring conduct by threat. "Intimidation" does not include age-appropriate discipline that may involve the threat to withhold privileges.

(5) "Neglect" means:

(a) Failure to provide the care, supervision, or services necessary to maintain the physical and mental health of a child in care; or

(b) The failure of a child-caring agency, proctor foster home, caretaker, or other person to make a reasonable effort to protect a child in care from abuse.

(6) "Sexual abuse" means:

(a) Sexual harassment, sexual exploitation, or inappropriate exposure to sexually explicit material or language;

(b) Any sexual contact between a child in care and an employee of a child-caring agency or proctor foster home, caretaker, or other person responsible for the provision of care or services to a child in care;

(c) Any sexual contact between a person and a child in care that is unlawful under ORS chapter 163 and not subject to a defense under that chapter; or

(d) Any sexual contact that is achieved through force, trickery, threat, or coercion.

(7) "Sexual contact" has the meaning given that term in ORS 163.305(1)(a)(E).

(8) "Sexual exploitation" as described in ORS 419B.005(1)(a)(E).

(9) "Verbal abuse" means to threaten significant physical or emotional harm to a child in care through the use of:

(a) Derogatory or inappropriate names, insults, verbal assaults, profanity, or ridicule; or

(b) Harassment, coercion, threats, intimidation, humiliation, mental cruelty, or inappropriate sexual comments.

Stat. Auth.: OL 2016, ch 10
Stats. Implemented: OL 2016, ch 10
Hist.: CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0630
Screening

(1) After gathering and documenting information required in OAR 413-015-0205(4)(a) the screener must determine whether the Department, the Office of Adult Abuse Prevention and Investigation (OAAPI) or both are required to respond to the report. Who responds to the report depends on the alleged victim, the alleged perpetrator and the type of abuse alleged.

(a) The Department determines the response to information alleging:

(A) Sexual abuse of a child in care, when the alleged perpetrator of the sexual abuse is a child or a child in care;

(B) Abuse of a child or young adult who resides in a child-caring agency or proctor foster home when the child or young adult does not receive services from the child-caring agency; or

(C) Abuse of a child in care when the alleged perpetrator is one of the following child-caring agencies or an employee of one of the following child-caring agencies:

(i) Academic Boarding School;

(ii) Adoption Agency; or

(iii) Homeless, Runaway and Transitional Living Shelters.

(b) The OAAPI determines the response to information alleging abuse of a child in care and the perpetrator is a proctor foster parent or one of the following child-caring agencies or an employee of one of the following child-caring agencies:

(A) Residential Care Agency;

(B) Day Treatment Agency;

(C) Foster Care Agency;

(D) Therapeutic Boarding School; or

(E) Outdoor Youth Program.

(2) Forward the report. When subsection (1)(b) of this rule applies, the screener must:

(a) Immediately pend the screening information to the OAAPI screener's workload.

(b) Immediately send an e-mail to the OAAPI screener to let the OAAPI screener know that a screening report has been assigned to the OAAPI screener's workload.

(c) When (1)(a) or (b) of this rule applies, document the information received in a second screening report form and then complete screening activities outlined in section (3) of this rule. When only subsection (1)(b) of this rule applies, screening activities are complete.

(3) Complete Screening Activities. When a screener determines the report is the responsibility of the Department as outlined in subsection (2)(a) of this rule, the screener must:

(a) Comply with 413-015-0205 to 0225; and

(b) When a report is closed at screening or referred for assessment, immediately notify the Department personnel assigned to ensure notifications outlined in Oregon Laws 2016, chapter 106 and OAR 413-080-0070 and document this notification in the Department's electronic information system case notes.

Stat. Auth.: OL 2016, ch 10
Stats. Implemented: OL 2016, ch 10
Hist.: CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-0640
Assessment

(1) When a report involving a child-caring agency or a proctor foster home is referred for a CPS assessment, the CPS worker must convene a staffing before making initial contact unless the timing of the staffing will compromise the safety of the child in care.

(a) The purpose of the staffing is:

(A) To determine and coordinate the response to the referral;

(B) To share information known by the Department regarding the children or young adults placed in the child-caring agency or proctor foster home; and

(C) To share information known by the Department regarding the child-caring agency or proctor foster home.

(b) The CPS worker must assure that the following people are invited to the staffing:

(A) The assigned caseworker of each child in care in the home or each caseworker's supervisor;

(B) A Department licensing coordinator;

(C) A manager, compliance specialist, or residential resource consultant from the Department's Well Being program; and

(D) An OAAPI investigator, if assigned.

(c) The CPS supervisor or designee must:

(A) Assure that the staffing discussed in subsection (a) of this section occurs prior to the initial contact unless the timing of the staffing will compromise the safety of the child in care;

(B) Determine whether the Child Welfare Program Manager and CPS Consultant should be invited to the staffing; and

(C) If the staffing does not occur prior to the initial contact, assure the staffing occurs the next business day and that all persons identified in subsection (b) of this section share information known by the Department regarding children or young adults placed in the child-caring agency or proctor foster home, the child-caring agency, employees of the child-caring agency, the proctor foster home, and any individuals living in the proctor foster home.

(2) The CPS worker must comply with OAR 413-015-0403 through 413-015-0485 and complete the following additional activities during the CPS assessment:

(a) Face-to-face contact and interview requirements.

(A) Prior to conducting an interview with a child in care the CPS worker must inform the child in care:

(i) When the child in care is not in the custody of the Oregon Youth Authority or the Department, that the child in care may have their parent or caregiver, or attorney present.

(ii) When the child in care is in the custody of the Oregon Youth Authority or the Department, that the child in care may have their attorney present.

(B) Notify and interview the owner, manager, operator, or appropriate authority responsible for the child-caring agency or proctor home. When this individual is also an alleged perpetrator, provide additional notification to an additional person responsible for the child-caring agency or proctor home. The CPS worker must meet with the owner, manager, operator, or appropriate authority responsible for the child-caring agency or proctor home at the beginning of the assessment to provide in person notification of the allegations, arrange for access to the facility, plan interviews that will take place at the facility, and gain access to names of other children, young adults, employees or other individuals who may have been a witness or could be a collateral contact.

(C) When completing a CPS assessment involving a child-caring agency the CPS worker must interview current and past employees of the child-caring agency that may have information regarding the alleged abuse or the alleged perpetrator.

(D) When completing a CPS assessment involving a child-caring agency the CPS worker must interview children and young adults, other than the alleged victim, including other children or young adults who reside in or have resided in the child-caring agency who:

(i) Witnessed the alleged abuse;

(ii) Have information pertinent to the CPS assessment; or

(iii) Have information pertinent to establishing the credibility of information gathered.

(E) Notify and interview the parent or caregiver of any child in care residing in or receiving services from the child-caring agency or proctor foster home who is selected to be interviewed during the assessment that is not in the legal custody of the Oregon Youth Authority or the Department and gain permission to interview the child in care. If the CPS worker is denied permission to interview, but such interviews are needed to complete the assessment, the CPS worker should consult with a supervisor and seek the assistance of a district attorney or assistant attorney general.

(b) When the CPS worker suspects a crime has been committed involving a child in care or at a child-caring agency or proctor foster home the CPS worker must report the suspected crime to law enforcement.

(c) Determine and Document Disposition of the CPS Assessment.

(A) As part of completing the CPS assessment, the CPS worker must determine and document that basis for the determination of whether there is reasonable cause to believe that abuse of a child in care occurred.

(B) When the determination of whether there is reasonable cause to believe that abuse of a child in care residing in or receiving services from a child-caring agency or proctor foster home occurred relates to reports of abuse as defined in ORS 419B.005 the possible determinations are outlined in 413-015-1000.

(C) When the determination of whether there is reasonable cause to believe that abuse of a child in care occurred relates to reports of abuse as defined in OAR 413-015-0625 the possible determinations are:

(i) "Substantiated" which means there is reasonable cause to believe that the abuse as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106, section 36 of a child in care occurred.

(ii) "Unsubstantiated" which means there is no evidence that the abuse as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106, section 36 of a child in care occurred.

(iii) "Inconclusive" which means there is some indication that the abuse as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106, section 36 occurred, but there is insufficient evidence to conclude that there is reasonable cause to believe that the abuse occurred.

(D) When determining whether there is reasonable cause to believe abuse occurred, the CPS worker must consider the behavior, conditions, and circumstances in the definition of abuse described in OAR 413-015-0625 and OAR 413-015-1000.

(d) Notification of the CPS Assessment Disposition. The CPS worker must comply with the notifications in OAR 413-015-0470 and the following additional notifications of the CPS Assessment Disposition:

(A) The CPS worker must notify the Department personnel assigned to ensure notifications outlined in Oregon Laws 2016, chapter 106 and OAR 413-080-0070.

(B) When the CPS assessment disposition is substantiated or founded for abuse of a child in care the CPS supervisor or designee must comply with the Reporting Sensitive Child Welfare Issues policy and complete a DHS150 Sensitive Issue Report.

Stat. Auth.: OL 2016, ch 10
Stats. Implemented: OL 2016, ch 10
Hist.: CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-1000
The CPS Assessment Dispositions

(1) This rule describes child abuse and neglect for the purpose of making CPS assessment dispositions related to a report of abuse as defined in ORS 419B.005.

(2) As part of completing the CPS assessment, the CPS worker must determine whether there is reasonable cause to believe child abuse or neglect occurred. The possible determinations are:

(a) "Founded," which means there is reasonable cause to believe that child abuse or neglect occurred.

(b) "Unfounded," which means no evidence of child abuse or neglect was identified or disclosed.

(c) "Unable to determine," which means there are some indications of child abuse or neglect, but there is insufficient data to conclude that there is reasonable cause to believe that child abuse or neglect occurred. The "unable to determine" disposition may be used only in the following circumstances:

(A) After extensive efforts have been made, the CPS worker is unable to locate the family; or

(B) After completing an assessment that complies with the Department's rules:

(i) The child is unable or unwilling to provide consistent information and there is insufficient information to support a founded or unfounded determination; or

(ii) There is conflicting or inconsistent information from collateral contacts or family, and there is insufficient information to support a founded or unfounded determination.

(d) When a CPS worker is assigned a CPS assessment the CPS supervisor may determine that no face-to-face contact is necessary with the alleged child victim and the alleged perpetrator of abuse only in the following circumstances:

(A) The assessment was opened in error. This is a determination that the referral is mistakenly opened.

(B) The reported information is addressed in another open CPS assessment. This is a determination that the report content is being included in another, currently open CPS assessment, under the same case number.

(C) The allegation was cleared through collateral contact. This is a determination that the CPS worker has, through collateral contacts, received information that indicates there is no longer a report of child abuse or neglect, as defined in 419B.005.

(3) When determining whether there is reasonable cause to believe child abuse or neglect occurred, the CPS worker shall consider, among others, the following parent or caregiver behavior, conditions, and circumstances:

(a) Abandonment, including parental behavior showing an intent to permanently give up all rights and claims to the child.

(b) Child selling, including the selling of a child that consists of buying, selling, bartering, trading, or offering to buy or sell the legal or physical custody of a child.

(c) Mental injury (psychological maltreatment), including cruel or unconscionable acts or statements made, threatened to be made, or permitted to be made by the parent or caregiver that has a direct effect on the child. The parent or caregiver's behavior, intentional or unintentional, must be related to the observable and substantial impairment of the child's psychological, cognitive, emotional, or social well-being and functioning.

(d) Neglect, including failure, through action or omission, to provide and maintain adequate food, clothing, shelter, medical care, supervision, protection, or nurturing. Chronic neglect is a persistent pattern of family functioning in which the parent or caregiver does not sustain or meet the basic needs of a child resulting in an accumulation of harm that can have long term effect on the child's overall physical, mental, or emotional development. Neglect includes each of the following:

(A) Physical neglect, which includes each of the following:

(i) Failing to provide for the child's basic physical needs including adequate shelter, food, and clothing.

(ii) Permitting a child to enter or remain in or upon premises where methamphetamines are being manufactured.

(iii) Unlawful exposure of a child to a substance that subjects a child to severe harm to the child's health or safety. When the CPS worker is making a determination of physical neglect based on severe harm to the child's

health due to unlawful exposure to a substance, this determination must be consistent with medical findings.

(B) Medical neglect is a refusal or failure to seek, obtain, or maintain necessary medical, dental, or mental health care. Medical neglect includes withholding medically indicated treatment from infants who have disabilities and life-threatening conditions. However, failure to provide the child with immunizations or routine well-child care alone does not constitute medical neglect. When the CPS worker is making a determination of medical neglect, this determination must be consistent with medical findings.

(C) Lack of supervision and protection, including failure to provide supervision and protection appropriate to the child's age, mental ability, and physical condition.

(D) Desertion, which includes the parent or caregiver leaving the child with another person and failing to reclaim the child, or parent or caregiver failure to provide information about their whereabouts, providing false information about their whereabouts, or failing to establish a legal guardian or custodian for the child.

(E) Psychological neglect, which includes serious inattention to the child's need for affection, support, nurturing, or emotional development. The parent or caregiver behavior must be related to the observable and severe harm of the child's psychological, cognitive, emotional, or social well-being and functioning.

(e) Physical abuse, including an injury to a child that is inflicted or allowed to be inflicted by non-accidental means that results in harm. Physical abuse may include injury that could not reasonably be the result of the explanation given. Physical abuse may also include injury that is a result of discipline or punishment. Examples of injuries that may result from physical abuse include:

(A) Head injuries

(B) Bruises, cuts, lacerations

(C) Internal injuries

(D) Burns or scalds

(E) Injuries to bone, muscle, cartilage, and ligaments

(F) Poisoning

(G) Electrical shock

(H) Death

(f) Sexual abuse, which includes a person's use or attempted use of a child for the person's own sexual gratification, the sexual gratification of another person, or the sexual gratification of the child. Sexual abuse includes incest, rape, sodomy, sexual penetration, fondling, and voyeurism.

(g) Sexual exploitation, including the use of a child in a sexually explicit way for personal gain, for example, to make money, in exchange for food stamps or drugs, or to gain status. Sexual exploitation also includes using children in prostitution or using children to create pornography.

(h) Threat of harm, including all activities, conditions, and circumstances that place the child at threat of severe harm of physical abuse, sexual abuse, neglect, mental injury, or other child abuse or neglect.

Stat. Auth.: ORS 409.050 & 418.005

Stats. Implemented: ORS 409.185, 418.015 & 419B.005 - 419B.050

Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 6-2005, f. & cert. ef. 4-1-05; CWP 19-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-30-06; CWP 14-2006, f. 6-30-06, cert. ef. 7-1-06; CWP 3-2007, f. & cert. ef. 3-20-07; CWP 25-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-27-08; CWP 7-2008, f. 6-27-08, cert. ef. 6-28-08; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-9030

Screening CPS Information — Determining Department's Response, Type of CPS Assessment, and Response Time Lines

Except as provided below, screeners in DR implementation counties must comply with OAR 413-015-0200 through 413-015-0225. OAR 413-015-0210(1) through (3) are replaced by the following:

(1) After the screener completes activities required by OAR 413-015-0205, and determines the information received is CPS information, the screener must determine the Department response, either CPS assessment required or close at screening. If a CPS assessment is required, the screener must determine the type of CPS assessment and the time line for the Department response.

(2) CPS assessment required. A CPS assessment is required if:

(a) The screener determines that information received constitutes a report of child abuse or neglect, as defined in ORS 419B.005, and the information indicates:

(A) The alleged perpetrator is a legal parent of the alleged child victim;

(B) The alleged perpetrator resides in the alleged child victim's home;

(C) The alleged perpetrator may have access to the alleged child victim, and the parent or caregiver may not be able or willing to protect the child; or

(D) The alleged child abuse occurred in a day care facility, or the home of a Department certified foster parent or relative caregiver.

(b) The screener determines that information received constitutes a report of abuse as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106, section 36 and the report is the responsibility of the Department as outlined in OAR 413-015-0630.

(c) A tribe or law enforcement agency (LEA) requests assistance from the Department with an investigation of child abuse or neglect, and a CPS supervisor agrees that assistance from the Department is appropriate.

(3) Type of CPS Assessment. If the screener determines that a CPS assessment is required, the screener must:

(a) Determine the type of CPS assessment required. The screener must determine if the report is assigned for a traditional response assessment or an alternative response assessment.

(A) Traditional Response Assessment. This type of CPS assessment is required when the report alleges or the information gathered indicates:

(i) The child has suffered or could likely suffer severe harm;

(ii) The abuse occurred in a day care facility, the home of a Department certified foster parent or relative caregiver, an Oregon Youth Authority (OYA) certified foster home, a child-caring agency, or a proctor foster home;

(iii) The perpetrator is a day care employee, certified foster parent or relative caregiver, an OYA certified foster parent, a child-caring agency employee, a proctor foster parent, a Department contracted service provider, an OYA employee, or a Department of Human Services employee;

(iv) There are multiple allegations in the same report and any of the allegations meet one of the criteria outlined in (i) through (iii) of this paragraph for a traditional response assessment;

(v) There is a prior report of child abuse or neglect that has not been assessed because the Department was unable to locate the family and the prior allegation or the current allegation meets the criteria for a traditional response assessment;

(vi) There is an open traditional response assessment and the date the open traditional response assessment was assigned is within 60 days of the date the new report will be assigned; or

(vii) There is an open Department case with an identified impending danger safety threat.

(B) Alternative Response Assessment. This type of CPS assessment is required when the report alleges or the information gathered indicates the child has suffered or could likely suffer harm, but the harm is not severe harm and none of the conditions outlined in (A)(i) through (vii) of this rule apply.

(b) Consult with a CPS supervisor. The screener must consult with the CPS supervisor or designee when the screener determines the type of CPS assessment required is a traditional response assessment and there is an open alternative response assessment.

(c) Document the type of CPS assessment required. The screener must document the type of CPS assessment required and document the justification for the determination.

(4) Response Time Lines. If the screener determines that a CPS assessment is required, the screener must:

(a) Determine the CPS assessment response time line. The time line for the Department response refers to the amount of time between when the report is received at screening and when the CPS worker is required to make an initial contact. When determining the response time, the screener must take into account the location of the child, how long the child will be in that location, and access that others have to the child.

(A) Traditional Response Assessment. The screener is required to assign the following response time lines for a traditional response assessment:

(i) A "within 24 hours" response time line unless (ii) below applies.

(ii) A "within five calendar days" response time line is only permitted for a traditional response assessment when the screener can clearly document how the information indicates child safety will not be compromised or an intentional delay to allow for a planned response is less likely to compromise the safety of the child.

(B) Alternative Response Assessment. The screener is required to assign the following response time lines for an alternative response assessment:

(i) A "within five calendar days" response time line is required unless (ii) below applies.

(ii) A "within 24 hours" response time line is only required for an alternative response assessment when the information indicates:

(I) A child is in danger right now; or

(II) A child has a current injury as a result of the alleged abuse or neglect.

(b) Complete a screening report form immediately when a "within 24 hour" response time line is assigned or the same day when a "within five calendar days" response time is assigned. A CPS supervisor may grant an extension for the completion of a screening report form as provided in OAR 413-015-0220.

(c) Refer the CPS assessment to the appropriate county as described in OAR 413-015-0213.

Stat. Auth: ORS 409.027, 409.050, 418.005, 418.598
Stats. Implemented: ORS 409.010, 409.185, 418.005, 418.015, 418.580, 419B.020
Hist.: CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 17-2014, f. & cert. ef. 12-24-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-015-9040
Assessment

(1) Except as provided in this rule, CPS workers in DR implementation counties must comply with OAR 413-015-0400 through 413-015-0485.

(2) Overview. The following outlines the primary components of all CPS assessments and the components unique to traditional response assessment and alternative response assessment.

(a) Completing a CPS assessment, whether traditional response assessment or alternative response assessment, involves all of the following:

(A) Making efforts to schedule the initial contact when a response timeline of "within five calendar" days is assigned.

(B) Making face-to-face contact with the alleged victim, his or her siblings, his or her parent or caregiver, other children and adults living in the home, and the alleged perpetrator.

(C) Accessing and viewing the home environment.

(D) Gathering safety-related information through interviews and observation.

(E) Determining if there is a present danger safety threat.

(F) Determining if there is an impending danger safety threat by applying the safety threshold criteria:

(i) Imminent;

(ii) Observable;

(iii) Vulnerable child;

(iv) Out of control; and

(v) Severity.

(G) Developing a protective action plan when a child is determined to be unsafe due to a present danger safety threat.

(H) Developing an initial safety plan when a child is determined to be unsafe due to an impending danger safety threat.

(I) Developing an ongoing safety plan when a child is determined to be unsafe from an impending danger safety threat at the conclusion of a CPS assessment.

(J) Determining whether the initial safety plan or ongoing safety plan is the least intrusive plan sufficient to manage child safety by identifying how the impending danger safety threat is occurring and applying the in-home safety plan criteria.

(K) Developing conditions for return when an out-of-home ongoing safety plan is established.

(L) Determining whether a family has moderate to high needs when a child is determined to be safe.

(M) Referring a family for a strengths and needs assessment and subsequently for community services when a family is determined to have moderate to high needs and accepts the referrals.

(b) In addition to the components of a CPS assessment outlined in paragraphs (a)(A) through (M) of this section, completing a traditional response assessment includes determining if there is reasonable cause to believe that child abuse or neglect occurred.

(c) In addition to the components of a CPS assessment outlined in paragraphs (a)(A) through (M) of this section, completing an alternative response assessment includes offering the family the option of having a community partner or support person accompany the worker when a response timeline of "within five calendar" days is assigned.

(3) Make Initial Contact. When completing a traditional response assessment or an alternative response assessment the CPS worker must comply with OAR 413-015-0420, "Make Initial Contact", and the additional requirements outlined in this section when a response timeline of "within five calendar days" is assigned:

(a) The CPS worker must make efforts to schedule the initial contact; and

(b) The CPS worker must, when completing an alternative response assessment:

(A) Offer the family the option of having a community partner or support person accompany the worker on initial contact;

(B) Obtain a release of information signed by the parent or caregiver specific to the identified community partner or support person; and

(C) Document, if applicable, whether the CPS worker completed the initial contact with a community partner or support person. When a community partner or support person was not present at initial contact, the CPS worker must document why not. When a community partner or support person was present, the CPS worker must document who was present.

(4) Change from Alternative Response Assessment to Traditional Response Assessment. When changing the type of CPS assessment from alternative response assessment to traditional response assessment the CPS worker must:

(a) Assure one of the following applies:

(A) Any of the criteria outlined in 413-015-9030(3)(a)(A)(i) through (vi);

(B) A referral is received on an open alternative response assessment within 60 days of the date the open assessment was assigned and the new referral meets the screening criteria to assign as a traditional response assessment;

(C) The CPS worker filed a petition alleging the child is within the jurisdiction of the juvenile court pursuant to ORS 419B.100; or

(D) The CPS worker determined the child is unsafe at the conclusion of the CPS assessment and an ongoing safety plan will be established and the case will be opened for services.

(b) Assure the decision is approved by a Department supervisor; and

(c) Document in the Department's electronic information system the decision to change from alternative response assessment to traditional response assessment and explain the basis for the decision.

(5) Make Child Safety Decision and Determine Whether to Open a Case. The CPS worker must comply with the requirements outlined in this section which replaces OAR 413-015-0445, "Child Safety Decision".

(a) After all the necessary information is gathered for the CPS assessment and the disposition has been determined, the CPS worker must determine if the child is safe or unsafe at the conclusion of the CPS assessment. To make a child safety decision at the conclusion of a CPS assessment, the CPS worker must again determine if an impending danger safety threat is present as outlined in OAR 413-015-0425, "Determine if there is a Present Danger Safety Threat or an Impending Danger Safety Threat".

(b) When at the conclusion of the CPS assessment the CPS worker determines one or more impending danger safety threats are present, including a previously identified impending danger safety threat that has not been eliminated, the CPS worker must conclude the child is unsafe. When the CPS worker concludes the child is unsafe at the conclusion of the CPS assessment, the CPS worker must:

(A) Determine how the impending danger safety threat is occurring to support the development of an ongoing safety plan as outlined in OAR 413-015-0428, "Identify How the Impending Danger Safety Threat is Occurring";

(B) Develop an ongoing safety plan as outlined in OAR 413-015-0450, "Develop an Ongoing Safety Plan";

(C) Complete the CPS assessment; and

(D) Open a case.

(c) When at the conclusion of the CPS assessment the CPS worker determines no present danger safety threats or impending danger safety threats are present and any identified previously have been eliminated, the CPS worker must conclude the child is safe. When the CPS worker concludes the child is safe at the conclusion of the CPS assessment, the CPS worker must:

(A) Dismiss the protective action plan or initial safety plan if one is in place; and

(B) Determine if the family has moderate to high needs unless completing a CPS assessment involving the home of a Department certified foster parent or relative caregiver, a child-caring agency, or a proctor foster home.

(d) When the CPS worker determines the family does not have moderate to high needs the CPS worker must complete and close the CPS assessment.

(e) When the CPS worker determines the family does have moderate to high needs, the CPS worker must offer the family the option to have a strengths and needs assessment completed by a strengths and needs assessment provider:

(A) If the family declines the offer to have a strengths and needs assessment completed the CPS worker must:

(i) Offer the family referrals to relevant non-contracted community services as available;

(ii) If the family accepts the offer, the CPS worker must refer the family to relevant non-contracted community services as available; and

(iii) Complete and close the CPS assessment.

(B) If the family accepts the offer to have a strengths and needs assessment completed the CPS worker must:

(i) Refer the family to a strengths and needs assessment provider;

(ii) Meet with the family and the strengths and needs assessment provider after the completion of the strengths and needs assessment, discuss contracted and non-contracted community service referral options, offer relevant community service referrals as available, and identify the family's preferences;

(iii) If the family accepts the offer for community service referrals, refer the family to relevant contracted or non-contracted community services as available.

(C) Complete and close the CPS assessment.

(f) The CPS worker must document in the Department's electronic information system the child safety decision including all of the following:

(A) If the child is safe and the assessment will be closed, or if the child is unsafe and the case will be opened.

(B) If the child is safe:

(i) Whether the family was determined to have moderate to high needs and the basis for the determination;

(ii) Whether the family accepted or declined to participate in a strengths and needs assessment and if they declined whether the family accepted the offer for relevant non-contracted community service referrals;

(iii) Whether the family accepted or declined to participate in services recommended as the result of the strengths and needs assessment; and

(iv) If applicable, what contracted or non-contracted community services were declined or accepted.

(6) CPS Assessment Documentation, Supervisory Review Requirements, and Extensions.

(a) The CPS worker must comply with OAR 413-015-0475, "CPS Assessment Documentation and Supervisory Review Requirements", with the exception of section (2) which this subsection replaces. The CPS worker must complete the CPS assessment and electronically submit the CPS assessment for review by a CPS supervisor, within 45 days of the day that the information alleging child abuse or neglect is received by the screener, except as provided in subsection (b) of this section.

(b) This subsection replaces OAR 413-015-0480, "CPS Assessment Extensions". The CPS supervisor may approve a one-time extension of an additional 15 days for completion of the CPS assessment if the supervisor has confirmed critical information (information necessary to determine child safety or a child abuse or neglect disposition) is outstanding or, if applicable, the strengths and needs assessment is not complete. Additional extension of time may be approved by the Child Welfare program manager if the ability to obtain critical information is beyond the reasonable control of the CPS worker.

Stat. Auth: ORS 409.027, 409.050, 418.005 & 418.598

Stats. Implemented: ORS 409.010, 409.185, 418.005, 418.015, 418.580 & 419B.020

Hist.: CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 13-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; CWP 17-2014, f. & cert. ef. 12-24-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-080-0050
Definitions

The following definitions apply to OAR 413-080-0040 to 413-080-0067:

(1) "Certified family" means an individual or individuals who hold a current Certificate of Approval from the Department to operate a home to provide care, in the home in which they reside, to a child or young adult in the care or custody of the Department.

(2) "Child" means a person under 18 years of age.

(3) "Child in care" means a person under 21 years of age who is residing in or receiving care or services from a child-caring agency or proctor foster home subject to ORS 418.205 to 418.328, 418.470, 418.470 or 418.950 to 418.970.

(4) "Child-caring agency" is defined in ORS 418.205 and:

(a) Means any private school, private agency, or private organization providing:

(A) Day treatment for children with emotional disturbances;

(B) Adoption placement services;

(C) Residential care, including but not limited to foster care or residential treatment for children;

(D) Residential care in combination with academic education and therapeutic care, including but not limited to treatment for emotional, behavioral or mental health disturbances;

(E) Outdoor youth programs; or

(F) Other similar care or services for children.

(b) Includes the following:

(A) A shelter-care home that is not a foster home subject to ORS 418.625 to 418.645

(B) An independent residence facility as described in ORS 418.475;

(C) A private residential boarding school; and

(D) A child caring facility as defined in ORS 418.950.

(c) Child-caring agency does not include:

(A) Residential facilities or foster care homes certified or licensed by the Department of Human Services under ORS 443.400 to 443.455, 443.830 and 443.835 for children receiving developmental disability services;

(B) Any private agency or organization facilitating the provision of respite services for parents pursuant to a properly executed power of attorney under ORS 109.056. For purposes of this subsection, 'respite services' means the voluntary assumption of short-term care and control of a minor child without compensation or reimbursement of expenses for the purpose of providing a parent in crisis with relief from the demands of ongoing care of the parent's child;

(C) A youth job development organization as defined in ORS 344.415;

(D) A shelter-care home that is a foster home subject to ORS 418.625 to 418.645; or

(E) A foster home subject to ORS 418.625 to 418.645.

(5) "Conditions for return" means a written statement of the specific behaviors, conditions, or circumstances that must exist within a child's home before a child can safely return and remain in the home with an in-home initial safety plan or in-home ongoing safety plan.

(6) "Contact" means any communication between Child Welfare staff and a child, parent or guardian, foster parent or relative caregiver, provider, or other individual involved in a Child Welfare safety plan or case. "Contact" includes, but is not limited to, communication in person, by telephone, by video-conferencing, or in writing. "Contact" may occur, for instance, during a face-to-face visit; a treatment review meeting for a child, young adult, parent, or guardian; a court or Citizen Review Board hearing; or a family meeting.

(7) "Department" means the Department of Human Services, Child Welfare.

(8) "DHS" means the Department of Human Services.

(8) "Face-to-face" means an in-person interaction between individuals.

(9) "Foster parent" means a person who operates a home that has been approved by the Department to provide care for an unrelated child or young adult placed in the home by the Department.

(10) "Guardian" means an individual who has been granted guardianship of a child through a judgment of the court.

(11) "ICPC" means the Interstate Compact for the Placement of Children (see ORS 417.200).

(12) "Impending danger safety threat" means a family behavior, condition, or circumstance that meets all five safety threshold criteria. A threat to a child that is not immediate, obvious, or occurring at the onset of the CPS intervention. This threat is identified and understood more fully by evaluating and understanding individual and family functioning.

(13) "Initial safety plan" means a documented set of actions or interventions sufficient to protect a child from an impending danger safety threat in order to allow for completion of the CPS assessment.

(14) "Monthly face-to-face contact" means in-person interaction between individuals at least once each and every full calendar month.

(15) "Ongoing safety plan" means a documented set of actions or interventions that manage a child's safety after the Department has identified one or more impending danger safety threats at the conclusion of a CPS assessment or anytime during ongoing work with a family.

(16) "Parent" means the biological or adoptive mother or the legal father of the child. A legal father is a man who has adopted the child or whose paternity has been established or declared under ORS 109.070, ORS 416.400 to 416.465, or by a juvenile court. In cases involving an Indian child under the Indian Child Welfare Act (ICWA), a legal father includes a man who is a father under applicable tribal law. "Parent" also includes a putative father who has demonstrated a direct and significant commitment to the child by assuming or attempting to assume responsibilities normally

associated with parenthood, unless a court finds that the putative father is not the legal father.

(17) "Present danger safety threat" means an immediate, significant, and clearly observable family behavior, condition or circumstance occurring in the present tense, already endangering or threatening to endanger a child. The family behavior, condition, or circumstance is happening now and it is currently in the process of actively placing a child in peril.

(18) "Proctor foster home" means a foster home certified by a child-caring agency that is not subject to ORS 418.625 to 418.645.

(19) "Protective action plan" means an immediate, same day, short-term plan, lasting a maximum of ten calendar days, sufficient to protect a child from a present danger safety threat.

(20) "Protective capacity" means behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person's ability and willingness to care for and keep a child safe.

(21) "Provider" means an employee of a child-caring agency approved to provide care for a child in care or a proctor foster parent.

(22) "Relative caregiver" means a person who operates a home that has been approved by the Department to provide care for a related child or young adult who is placed in the home by the Department.

(23) "Safety service provider" means a participant in a protective action plan, initial safety plan, or ongoing safety plan whose actions, assistance, or supervision help a family in managing a child's safety.

(24) "Safety services" means the actions, assistance, and supervision provided by safety service providers to manage the identified present danger safety threats or impending danger safety threats to a child.

(25) "Screener" means a Department employee with training required to provide screening services.

(26) "Sex trafficking" means the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person under the age of 18 for the purpose of a commercial sex act or the recruitment, harboring, transportation, provision, or obtaining of a person over the age of 18 using force, fraud, or coercion for the purpose of a commercial sex act.

(27) "Social service assistant" means a Department employee with training required to provide services to assist a caseworker on an open case.

(28) "Substitute care" means the out-of-home placement of a child or young adult who is in the legal or physical custody and care of the Department.

(29) "Young adult" means a person aged 18 through 20 years.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Hist.: CWP 3-2004(Temp), f. & cert. ef. 3-1-04 thru 8-27-04; CWP 15-2004, f. & cert. ef. 8-25-04; CWP 4-2007, f. & cert. ef. 3-20-07; CWP 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; CWP 21-2009, f. & cert. ef. 12-29-09; CWP 1-2013, f. & cert. ef. 1-15-13; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 18-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 3-28-16; CWP 25-2015(Temp), f. & cert. ef. 11-24-15 thru 5-21-16; CWP 27-2015, f. 12-28-15, cert. ef. 1-1-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-080-0051
Addressing a Present Danger Safety Threat or New Impending Danger Safety Threat on an Open Case

(1) If Department staff determine a child or child in care is unsafe due to a present danger safety threat as described in OAR 413-015-0425(1) on a case opened under OAR 413-015-0445(2)(d), staff must immediately consult with a supervisor and establish a protective action plan as described in OAR 413-015-0435. The ongoing safety plan remains in place to address the existing impending danger safety threats.

(2) If Department staff determine a child or child in care is unsafe due to a new impending danger safety threat as described in OAR 413-015-0425 (2) on a case opened under OAR 413-015-0445(2)(d), staff must immediately consult with a supervisor and modify the ongoing safety plan; and

(3) Department staff must document the behaviors, conditions, or circumstances observed and any protective action plan taken, or modification made to the ongoing safety plan, in the Department's electronic information system.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Hist.: CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-080-0052
Addressing a Concern in a Child-Caring Agency or Proctor Foster Home

(1) When Department staff through information gathering or observation have a concern, including when well-being needs are not being met, involving a child in care staff must immediately:

(a) Notify Department personnel assigned to ensure notifications outlined in OAR 413-080-0070. This does not include allegations of abuse or neglect as defined in ORS 419B.005 or Oregon Laws 2016, chapter 106, section 36, which are reported to a Department screener;

(b) Document the notification in OR-Kids case notes; and

(c) Make efforts to address the concern for the child in care.

(2) When Department staff suspect a crime has been committed involving a child in care or at a child-caring agency or proctor foster home staff must report the suspected crime to law enforcement.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Hist.: CWP 4-2007, f. & cert. ef. 3-20-07; CWP 21-2009, f. & cert. ef. 12-29-09; CWP 1-2013, f. & cert. ef. 1-15-13; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-080-0054
Monthly Face-to-Face Contact Requirements

(1) A child or young adult in a child welfare case.

(a) Except as provided in section (2) of this rule, monthly face-to-face contact with a child or young adult in a child welfare case must be made by one of the following Department staff to ensure the safety, permanency, and well-being of the child or young adult:

(A) The primary caseworker;

(B) The caseworker's supervisor; or

(C) When designated by the caseworker's supervisor as described in OAR 413-080-0067;

(i) Another caseworker or supervisor; or

(ii) A social service assistant.

(b) During the face-to-face contact required in section (1) of this rule, Department staff must:

(A) Ensure the safety, permanency, and well-being of the child or young adult;

(B) Address issues pertinent to case planning and service delivery during the contact;

(C) Notify a supervisor when he or she determines that the ongoing safety plan or the living environment is insufficient to ensure the safety of the child or young adult to determine if a protective action plan is necessary to ensure safety; and

(D) Notify a certifier when the well-being needs of a child or young adult are not being met by a certified family.

(E) Comply with OAR 413-080-0051 and 413-080-0052 if there is any concern about the safety or well-being of a child in care.

(c) Department staff making face-to-face contact must document in the Department's electronic information system:

(A) The date, type, and location of each contact with the child, young adult, parent, or guardian; and

(B) The issues addressed during the contact and notifications made as a result of the contact.

(d) A face-to-face contact with a child or young adult made by a social service assistant;

(A) May be reported as the required face-to-face contact no more than one time in any three-month period and no more than a four times within a year; and

(B) May not be reported as the required face-to-face contact for consecutive months.

(e) Face-to-face contact with a child or young adult in substitute care must occur in the substitute care placement every other month.

(f) When face-to face contact with a child or young adult in substitute care is not possible because the child or young adult is missing, the caseworker must comply with OAR 413-080-0053.

(2) A parent or guardian on a child welfare case.

(a) When there is an in-home ongoing safety plan, Department staff must have monthly face-to-face contact in the home with the parents or guardians living in the home with the child.

(b) A caseworker must have face-to-face contact with the child and the child's parent or guardians within five working days of learning any of the following:

(A) A condition of the ongoing safety plan has been violated.

(B) A change in the protective capacity, the family circumstances, or the composition of the household of a parent or guardian may negatively impact the ongoing safety plan.

(C) The caseworker is assigned a case that had been assigned to another caseworker (case transfer).

(c) Department staff must have monthly face-to-face contact with the parents or guardians, unless a supervisor approves an exception to contact with the non-custodial parent who has an in-home ongoing safety plan or, when there is an out-of-home ongoing safety plan, the parent or guardian is unavailable or the contact could compromise the caseworker's safety. The

supervisor's exception must be documented in the Department's electronic information system and must document:

(A) The reason for the exception; and

(B) The length of time the exception is in effect, which is not longer than 90 days unless a longer period is approved by a Child Welfare Program Manager.

(3) The substitute caregiver.

(a) Department staff described in subsection (1)(a) of this rule must have monthly contact with the certified family or provider.

(b) The face-to-face contact with the child or young adult required in subsection (1)(e) of this rule must include at least one of the certified adults or providers who provide direct care for the child or young adult.

(4) A child or young adult placed through ICPC or placed internationally.

(a) When a child or young adult is placed in another state through the ICPC or placed internationally, the caseworker must request that officials from the receiving state or country have monthly face-to-face contact to monitor child safety, permanency, and well-being.

(b) When the receiving state or country's child welfare office is unwilling or unable to have monthly face-to-face contact with the child or young adult, a plan must be developed to meet this requirement.

(c) The caseworker must document in the case file the type and level of contact the receiving state or country will provide and how the contact is sufficient to confirm the safety and well-being of the child or young adult.

(d) The documentation received from the receiving state or country must be filed in the Department's electronic information system.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 418.005

Hist.: CWP 1-2013, f. & cert. ef. 1-15-13; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 18-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 3-28-16; CWP 27-2015, f. 12-28-15, cert. ef. 1-1-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-080-0059

Monitoring the Out-of-Home Ongoing Safety Plan

(1) To manage an out-of-home ongoing safety plan, the caseworker must have monthly contact with the following individuals:

(a) Face-to-face contact with the child or child in care, or review the documentation of the contact made by Department staff under OAR 413-080-0054(1);

(b) Face-to-face contact with the child's parents or guardians, except as provided in OAR 413-080-0054(2); and

(c) Contact with each safety service provider.

(2) The caseworker must determine whether the child or child in care is safe.

(3) The caseworker must determine whether:

(a) Behaviors, conditions, or circumstances within the family require an increase in the level of safety intervention;

(b) Conditions for return have been achieved and an in-home ongoing safety plan can assure the safety of the child; and if so, must develop an in-home ongoing safety plan under the criteria set forth in OAR 413-015-0450; or

(c) The ongoing safety plan is keeping the child or child in care safe and provides the appropriate level of safety intervention.

(4) If the caseworker determines the out-of-home ongoing safety plan must still be in place but level of intervention of the out-of home ongoing safety plan must be revised, the caseworker must:

(a) Reduce the level of intervention whenever;

(A) The improved protective capacity of the parent or guardian is sufficient to impact his or her ability to control the impending danger safety threats as they are occurring within the family; and

(B) An impending danger safety threat can be managed with less intrusive actions or services.

(b) Increase the level of intervention whenever an identified impending danger safety threat cannot be managed with the current ongoing safety plan.

(5) The revised ongoing safety plan must:

(a) Comply with the criteria of OAR 413-015-0450; and

(b) Be approved by the caseworker's supervisor.

(6) Department staff must document in the Department's information system:

(a) How the ongoing safety plan continues to manage the impending danger safety threats as they are occurring within the family, or any revised ongoing safety plan and the facts supporting that revision; and

(b) Any protective action plan if required to assure the safety of the child or child in care.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 418.005

Hist.: CWP 4-2007, f. & cert. ef. 3-20-07; CWP 10-2007(Temp), f. 5-14-07, cert. ef. 5-15-07 thru 11-9-07; CWP 18-2007, f. & cert. ef. 11-1-07; CWP 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; CWP 21-2009, f. & cert. ef. 12-29-09; CWP 1-2013, f. & cert. ef. 1-15-13; CWP 10-2014, f. 5-20-14, cert. ef. 5-27-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-080-0070

Notifications When Reports Are Made Regarding Child Safety or Compliance in a Child-Caring Agency or Proctor Foster Home

(1) When DHS becomes aware that any suspected or founded abuses, deficiencies, violations, or failures to comply with the full compliance requirements described in ORS 418.240 or OAR chapter 413, division 215, whether through a report to the Department from the public or from DHS staff under ORS 418.260, are occurring in a child-caring agency or proctor foster home, the Department must immediately report the alleged abuses, deficiencies, violations, or failures to comply to:

(a) The state or governmental agency or unit, governing board, trustees, owners, managers or operators or other appropriate authorities responsible for the child-caring agency.

(b) Any governmental agency or unit that has a contract with the child-caring agency to provide care or services to a child.

(c) Appropriate personnel within DHS including, but not limited to:

(A) The Office of Licensing and Regulatory Oversight;

(B) The Department's Well Being Program when the child-caring agency or proctor foster home has a contract to provide Behavior Rehabilitation Services (BRS); and

(C) The Office of Developmental Disabilities Services when the child-caring agency or proctor foster home is also licensed to provide intellectual or developmental disabilities services to children.

(d) When the report is an allegation of abuse against a child in care, including a report that has been closed at screening, notify:

(A) The caseworker for the child in care;

(B) The attorney for the child in care;

(C) The child in care's court appointed special advocate;

(D) The parents or guardians of the child in care; and

(E) Attorney representing a parent or guardian of the child in care.

(2) When a report of abuse of a child in care is substantiated or founded DHS must notify all of the following persons and entities of the disposition:

(A) The Director of DHS.

(B) The Office of Licensing and Regulatory Oversight.

(C) The Director of Child Welfare.

(D) Case managers for the child in care;

(E) The court appointed special advocate, if any, for the child in care; and

(F) The attorney for the child in care, if any.

(G) The parents or guardians of the child in care who is the subject of the abuse report and investigation if the child in care has not been committed to the custody of DHS or the Oregon Youth Authority. Notification under this paragraph may not include any details or information other than that a report of abuse has been substantiated.

(H) The parents or guardians of each child in care that is residing, or receiving care or services, at the child-caring agency or proctor foster home that is the subject of the report and investigation, if the child in care has not been committed to the custody of DHS or the Oregon Youth Authority. Notification under this paragraph may not include any details or information other than that a report of abuse has been substantiated.

(I) Any governmental agency or unit that has a contract with the child-caring agency to provide care or services to a child in care.

(3) Licensing actions.

(a) When DHS places conditions on any license or suspends or revokes a license under OAR 413-215-0121, DHS must immediately notify any governmental agency or unit that has a contract with the child-caring agency to provide care or services to a child.

(b) If DHS determines that the child-caring agency has deficiencies, violations, or failures to comply with a license or contract and DHS imposes a plan of correction that the child-caring agency does not comply with in the time allotted for correction, DHS must immediately notify all of the following of the failure of the child-caring agency to comply with the plan of correction:

(A) The Legislative Assembly or the interim committees of the Legislative Assembly relating to child welfare.

(B) The state or governmental agency or unit, governing board, trustees, owners, managers or operators or other appropriate authorities responsible for the child-caring agency.

(C) Any governmental agency or unit that has a contract with the child-caring agency to provide care or services to a child.

(4) DHS is required to immediately investigate these reports and take appropriate actions. Investigation of reports is governed by rules in OAR chapter 407, division 045 and OAR chapter 413, divisions 15, 90, and 215.

Stat. Auth.: ORS 418.005, Or Laws 2016, ch 106
Stats. Implemented: ORS 418.005, Or Laws 2016, ch 106
Hist.; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-090-0000
Definitions

The following definitions apply to OAR 413-090-0000 to 413-090-0550:

(1) "Absent day" means a calendar day that:

(a) The BRS client (see OAR 410-170-0020) is enrolled in but not physically present in the program of the BRS provider (see OAR 410-170-0020);

(b) Does not meet the definition of a billable care day (see OAR 410-170-0020);

(c) The Department's placement plan is to return the BRS client to the BRS provider; and

(d) The BRS contractor (see OAR 410-170-0020) or BRS provider obtains authorization from the BRS client's caseworker (see OAR 410-170-0020) and the contract administrator to bill the calendar day as an "absent day".

(2) "Abuse check" means obtaining and reviewing abuse allegations and abuse investigation reports and associated exhibits and documents for the purpose of determining whether a subject individual has a history as a perpetrator of potentially disqualifying abuse (a potentially disqualifying condition) as described in OAR 407-007-0290(11).

(3) "Adoption assistance payment" means a monthly payment made by the Department to the pre-adoptive family or adoptive family on behalf of an eligible child or young adult.

(4) "Babysitting" means the provision of temporary, occasional care for a child or young adult that is:

(a) Ten consecutive hours or less; and

(b) Not overnight care.

(5) "Background Check Unit (BCU)" means the Department of Human Services Background Check Unit.

(6) "Base rate payment" means a payment to the foster parent or relative caregiver for the costs of providing the child or young adult with the following:

(a) Food, including the special or unique nutritional needs of the child or young adult;

(b) Clothing, including purchase and replacement;

(c) Housing, including maintenance of household utilities, furnishings, and equipment;

(d) Daily supervision, including teaching and directing to ensure safety and well-being at a level appropriate for the chronological age of the child or young adult;

(e) Personal incidentals, including personal care items, entertainment, reading materials, and miscellaneous items; and

(f) Transportation, including gas, oil, and vehicle maintenance and repair costs for local travel associated with providing the items listed above, and transportation to and from extracurricular, child care, recreational, and cultural activities.

(7) "CANS screening" means Child and Adolescent Needs and Strengths screening, a process of gathering information on the needs and strengths of a child or young adult for one or more of the following purposes:

(a) To identify case planning, service planning, and supervision needs of the child or young adult in substitute care with a certified family; and

(b) To determine the level of care payment while in substitute care with a certified family; and

(c) To determine the level of care payment included in an adoption assistance agreement or guardianship assistance agreement.

(8) "Certified family" means an individual or individuals who hold a current Certificate of Approval from the Department to operate a home to provide care, in the home in which the individual or individuals reside, to a child or young adult in the care or custody of the Department.

(9) "Chafee housing payment" means a payment to assist in covering the costs of room and board made to an eligible individual between 18 and 20 years of age who was discharged from the care and custody of the Department or one of the federally recognized tribes on or after reaching 18 years of age.

(10) "Child" means a person under 18 years of age.

(11) "Child in care" means a person who is under 21 years of age who is residing in or receiving care or services from a child caring agency or proctor foster home.

(12) "Child-caring agency" is defined in ORS 418.205 and means a "child-caring agency" that is not owned, operated, or administered by a governmental agency or unit.

(13) "Clothing replacement allowance" means an allowance included in the substitute care maintenance payments to a provider to cover the cost of maintaining adequate clothing for each child or young adult in the substitute care maintenance payments to the provider.

(14) "Contract administrator" means the employee or other individual designated in writing by the Department, by name or position description, to conduct the contract administration of a contract or class of contracts.

(15) "Contract registered nurse" means a licensed registered nurse under a contract with the Department who provides nursing assessment, consultation, teaching, delegation, or on-going nursing services to a child or young adult in the care or custody of the Department.

(16) "Criminal records check" means obtaining and reviewing criminal records as required by these rules and includes any or all of the following:

(a) An Oregon criminal records check in which criminal offender information is obtained from the Oregon State Police (OSP) using the Law Enforcement Data System (LEDS). An Oregon criminal records check may also include a review of other criminal records information obtained from other sources.

(b) A national criminal records check in which records are obtained from the Federal Bureau of Investigation (FBI) through the use of fingerprint cards sent to OSP and other identifying information. A national criminal records check may also include a review of other criminal records information.

(c) A state-specific criminal records check where records are obtained from law enforcement agencies, courts, or other criminal records information resources located in, or regarding, a state or jurisdiction outside Oregon.

(17) "Delegated nursing task" means a task, normally requiring the education and license of a registered nurse (RN) and within the RN scope of practice to perform, that an RN authorizes an unlicensed person to perform.

(18) "Department" means the Department of Human Services, Child Welfare.

(19) "Dependent parent" means a child or young adult in the legal custody of the Department who is the parent of a child.

(20) "Enhanced shelter care payment" means a limited term payment provided to a certified family when a child or young adult in the care or custody of the Department moves to a certified family's home from a placement with a BRS provider and there is no current level of care determination applicable to the child or young adult.

(21) "Enhanced supervision" means the additional support, direction, observation, and guidance necessary to promote and ensure the safety and well-being of a child or young adult when the child or young adult qualifies for a level of care payment.

(22) "Foster care payments" means one or more of the following payments to a certified family, authorized at rates established by the Department, for the board and care of a child or young adult for whom the Department has placement and care responsibility:

(a) The base rate payment;

(b) The level of care payment, if any;

(c) Shelter care payment or enhanced shelter care payment;

(d) Mileage reimbursement, paid at the current Department mileage reimbursement rate to child welfare staff, for transportation of a child or young adult remaining in the same school he or she was attending prior to placement in substitute care; and

(e) The board and care of the child of a dependent parent, unless the dependent parent receives cash benefits under a program administered by the Department of Human Services under chapter 461 of the Oregon Administrative Rules.

(23) "Foster parent" means an individual who operates a home that has been approved by the Department to provide care for an unrelated child or young adult placed in the home by the Department.

(24) "Guardian" means an individual who has been granted guardianship of the child through a judgment of the court.

(25) "Guardianship assistance agreement" means a written agreement, binding on the parties to the agreement, between the Department and the potential guardian or guardian setting forth the assistance the Department is to provide on behalf of the child or young adult, the respon-

sibilities of the guardian and the Department, and the manner in which the agreement and amount of assistance may be modified or terminated.

(26) "Independent living housing subsidy" means a payment to assist in covering the cost of room, board, or other monthly expenses made to an eligible individual who is at least 16 years of age and is in the care and custody of the Department and living independently.

(27) "Legally responsible relative" means the parent or stepparent of a child or young adult or a person related to the child or young adult by blood or marriage who has legal custody or legal guardianship of the child or young adult.

(28) "Level of care payment" means the payment provided to an approved or certified family, a guardian, a pre-adoptive family, or an adoptive family based on the need for enhanced supervision of the child or young adult as determined by applying the CANS algorithm to the results of the CANS screening.

(29) "Level of personal care payment" means the payment to a qualified provider for performing the personal care services for an eligible child or young adult based on the child's or young adult's need for personal care services as determined by applying the personal care services algorithm to the results of the personal care services rating scale.

(30) "Other criminal records information" means information obtained and used in the criminal records check process that is not criminal offender information from OSP. "Other criminal records information" includes, but is not limited to, police investigations and records, information from local or regional criminal records information systems, justice records, court records, information from the Oregon Judicial Information Network, sexual offender registration records, warrants, Oregon Department of Corrections records, Oregon Department of Transportation Driver and Motor Vehicle Services Division information, information provided on the background check requests, disclosures by a subject individual, and any other information from any jurisdiction obtained by or provided to the Department for the purpose of conducting a fitness determination.

(31) "Personal Care Nurse Coordinator" means a registered nurse (RN) who is a licensed registered nurse employed by the Department to provide oversight of contract registered nurses and personal care services authorized through the Department.

(32) "Personal care services" means the provision of or assistance with those functional activities described in OAR 413-090-0120 consisting of mobility, transfers, repositioning, basic personal hygiene, toileting, bowel and bladder care, nutrition, medication management, and delegated nursing tasks that a child or young adult requires for his or her continued well-being.

(33) "Personal care services assessment" means an evaluation by a registered nurse of a child or young adult's ability to perform the functional activities required to meet the child or young adult's daily needs.

(34) "Personal care services plan" means a written plan to provide personal care services for the child or young adult documenting:

(a) The determination that the individual is a qualified provider;

(b) The frequency or intensity of each personal care service to be provided; and

(c) The date personal care services begin.

(35) "Potential guardian" means an individual who:

(a) Has been approved by the Department or participating tribe to be the guardian of a child or young adult; and

(b) Is in the process of legalizing the relationship to the child through the judgment of the court.

(36) "Pre-adoptive family" means an individual or individuals who:

(a) Has been selected to be a child's adoptive family; and

(b) Is in the process of legalizing the relationship to the child through the judgment of the court.

(37) "Proctor foster home" means a foster home certified by a child-caring agency that is not subject to ORS 418.625 to 418.645.

(38) "Qualified provider" means an individual who:

(a) Is authorized by the Department through the contract registered nurse or Personal Care Nurse Coordinator;

(b) Demonstrates by background, skills, and abilities the capability to safely and adequately provide the authorized personal care services;

(c) Maintains a drug-free household;

(d) Has been approved through the background check process described in OAR 413-120-0400 to 413-120-0475 or under OAR 407-007-0200 to 407-007-0370; and

(e) Is not the parent, step-parent, or legally responsible relative of the child or young adult eligible for personal care services.

(39) "Registered nurse" means an individual licensed and registered to practice nursing.

(40) "Relative caregiver" means an individual who operates a home that has been approved by the Department to provide care for a related child or young adult placed in the home by the Department.

(41) "SAIP" means Secure Adolescent Inpatient Program.

(42) "SCIP" means Secure Adolescent Inpatient Program.

(43) "SDA" means Service Delivery Area (SDA)" means a geographic region of one or more counties served by the Department and managed by an SDA Manager.

(44) "Shelter care payment" means a payment provided to a certified family during the first 20 days of substitute care for a child or young adult in the care or custody of the Department.

(45) "Subject individual" means an individual described in OAR 407-007-0030(30)(a).

(a) For the purposes of these rules, a "subject individual" also includes:

(A) An individual who provides respite care (see OAR 410-170-0020) for an approved provider parent (see OAR 410-170-0020);

(B) An individual who volunteers with or is employed by an approved provider parent to assist with the care of a BRS client, other than an individual who provides babysitting unless paragraph (D) of this subsection applies;

(C) An individual 18 years of age or older who is living in the home of an approved provider parent;

(D) An individual under 18 years of age who is living in the home of an approved provider parent if there is reason to believe the individual may pose a risk to a BRS client;

(E) An individual who provides babysitting or an individual who frequents the home of an approved provider parent if there is reason to believe the individual may pose a risk to a BRS client; and

(F) An individual who has access to a BRS client in the home of an approved provider parent if the contract administrator has requested a criminal records check on the individual.

(b) The following individuals are not subject individuals:

(A) A child or young adult in the care or custody of the Department who lives in the home of the approved provider parent; and

(B) A BRS client.

(47) "Transitional visit" means an overnight visit by the BRS client to another placement for the purpose of facilitating the BRS client's transition.

(48) "Vendor Attorneys" means qualified attorneys, including Legal Aide Programs who have signed a legal fees agreement with the Department to accept the Department's currently established standard payment, plus reimbursement of any personal costs incurred, for court fees and the filing of mandatory court papers, or for obtaining birth certificates when establishing guardianships for children in the care and custody of the Department, or to process adoptions.

(49) "Young adult" means a person aged 18 through 20 years.

Stat. Auth.: ORS 418.005

Stats. Implemented: ORS 418.005

Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; CWP 9-2003, f. & cert. er. 1-7-03; CWP 20-2006(Temp), f. & cert. ef. 10-13-06 thru 4-10-07; CWP 5-2007, f. 3-30-07, cert. ef. 4-1-07; CWP 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; CWP 9-2009(Temp), f. & cert. ef. 8-12-09 thru 12-28-09; CWP 10-2009(Temp), f. & cert. ef. 9-1-09 thru 12-28-09; CWP 11-2009(Temp), f. & cert. ef. 9-25-09 thru 12-28-09; CWP 21-2009, f. & cert. ef. 12-29-09; CWP 12-2011(Temp), f. & cert. ef. 6-30-11 thru 12-27-11; CWP 28-2011, f. 11-3-11, cert. ef. 11-4-11; CWP 13-2015, f. & cert. ef. 8-4-15; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-090-0055
Effective Date and Administration of the BRS Program

(1) BRS contractors (see OAR 410-170-0020) and BRS providers (see OAR 410-170-0020) that provide services (see OAR 410-170-0020) to a child (see OAR 410-170-0020) or young adult (see OAR 410-170-0020) in the care or custody of the Department of Human Services or one of the federally recognized tribes in Oregon must comply with the requirements in the BRS program general rules (OAR 410-170-0000 through 410-170-0120) and these rules (OAR 413-090-0055 through 413-090-0090).

(2) All references to federal and state laws and regulations referenced in these rules are those in place on July 1, 2016 and the Agency-specific BRS program rules that are effective on July 1, 2016.

Stat. Auth.: ORS 183.355, 409.050, 418.005, 411.060, 411.070 & 411.116

Stats. Implemented: ORS 418.005, 418.015, 418.027, 411.070, 411.116, 411.141, 418.285, 418.312, 418.315, 418.490 & 418.495

Hist.: CWP 10-2013, f. 11-14-13, cert. ef. 1-1-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-090-0065
Definitions

Definitions for OAR 413-090-0055 to 413-090-0090 are in 413-090-0000 and 410-170-0020.

Stat. Auth.: ORS 181.534, 181.537, 409.050, 411.060, 411.070, 411.116, 418.005
Stats. Implemented: ORS 181.534, 181.537, 409.010, 409.025, 409.027, 411.060, 411.070, 411.116, 411.141, 418.005, 418.015, 418.016, 418.027, 418.285, 418.312, 418.315, 418.490, 418.495
Hist.: CWP 10-2013, f. 11-14-13, cert. ef. 1-1-14; CWP 13-2015, f. & cert. ef. 8-4-15; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-090-0070
BRS Provider Requirements

In addition to the requirements in OAR 410-170-0030, the BRS contractor (see OAR 410-170-0020) and the BRS provider (see OAR 410-170-0020) providing services (see OAR 410-170-0020) and placement-related activities (see OAR 410-170-0020) to a BRS client (see OAR 410-170-0020) in the care or custody of the Department or one of the federally-recognized tribes in Oregon must comply with all of the following requirements:

(1) Ensure completion of a background check, including a criminal records check and an abuse check, on each subject individual in compliance with OAR 407-007-0210 to 407-007-0380.

(2) Ensure the following documents are contained in the individual, confidential file of each BRS client:

(a) A face sheet with frequently referenced information;

(b) The BRS client's medical insurance information;

(c) The BRS client's school enrollment, attendance, progress, and discipline information during the BRS client's stay in the program;

(d) Signed consent for the BRS client to participate in the BRS program;

(e) Documentation regarding the individuals authorized to consent to medical or mental health services for the BRS client;

(f) Documentation regarding home or other family visits:

(g) Documentation of recreational, social, and cultural activities;

(h) Documentation of legal custody or voluntary placement status;

(i) Referral information;

(j) All services documentation including, but not limited to the ISP, AER, MSP, MSP updates, Discharge Summary, and Aftercare Summary as required by BRS service planning in OAR 410-170-0070;

(k) Any restrictions on or special permissions for the BRS client's participation in activities or outings and the duration of any restrictions or special permissions; and

(l) All other case related information specific to the BRS client.

(3) The BRS contractor and the BRS provider must maintain in their program records:

(a) Staff schedules for BRS programs utilizing a residential care model (see OAR 410-170-0020);

(b) Certification status for proctor foster home for BRS programs utilizing a therapeutic foster care model (see OAR 410-170-0020); and

(c) Authorization for each absent day billed for a BRS client.

(4) The BRS contractor and BRS provider including a proctor foster home must permit immediate access to a child in care and to any area of the premises upon which the child in care receives care or services to all individuals and for all purposes described in ORS 418.305.

Stat. Auth.: ORS 181.534, 181.537, 409.050, 411.060, 411.070, 411.116, 418.005
Stat. Implemented: ORS 181.534, 181.537, 409.010, 409.025, 409.027, 411.060, 411.070, 411.116, 411.141, 418.005, 418.015, 418.016, 418.027, 418.285, 418.312, 418.315, 418.490, 418.495
Hist.: CWP 10-2013, f. 11-14-13, cert. ef. 1-1-14; CWP 13-2015, f. & cert. ef. 8-4-15; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-090-0075
Prior Authorization for the BRS program; Appeal Rights

(1) BRS Program Eligibility.

(a) The Department may provide prior authorization for the BRS program to a child in care who:

(A) Meets the requirements in OAR 410-170-0040(2)(a)(A) through (C); and

(B) Is in the care or custody of the Department or one of the federally recognized tribes in Oregon.

(b) Notwithstanding subsection (1)(a) of this rule, the Department may provide prior authorization for the BRS program to a child in care who:

(A) Meets the requirements in OAR 410-170-0040(2)(a)(B) through (E);

(B) Is eligible for state-funded medical assistance under Title XIX and General Assistance Medical Eligibility, OAR 413-100-0400 through 413-100-0610; and

(C) Is in the care or custody of the Department or one of the federally recognized tribes in Oregon.

(2) Appeal Rights.

(a) When a child in care in the care or custody of the Department or a federally recognized tribe in Oregon is denied prior authorization for the BRS program under subsection (1)(a) of this rule, he or she is entitled to notice and contested case hearing rights under OAR 410-120-1860 to 410-120-1865. The contested case hearing will be held by the Authority (see OAR 410-170-0020).

(b) When a child in care in the care or custody of the Department and who is enrolled in the Oregon Health Plan is denied prior authorization for the BRS program under subsection (1)(b) of this rule, he or she is entitled to notice and contested case hearing rights under OAR 413-010-0500 to 413-010-0535. The contested case hearing will be held by the Department.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.116 & 418.005
Stat. Implemented: ORS 409.010, 411.060, 411.070, 411.095, 411.116, 411.141, 418.005, 418.015, 418.027, 418.285, 418.312, 418.315, 418.490 & 418.495
Hist.: CWP 10-2013, f. 11-14-13, cert. ef. 1-1-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-090-0080
BRS Placement Related Activities for a Department BRS Contractor and BRS Provider

(1) A BRS contractor (see OAR 410-170-0020) and BRS provider (see OAR 410-170-0020) must coordinate all placement-related activities (see OAR 410-170-0020) for the BRS client (see OAR 410-170-0020) with the BRS client's Department or tribal caseworker (see OAR 410-170-0020) to ensure these activities support the child welfare case plan and the child specific case plan.

(2) A BRS contractor and BRS provider must provide facilities, personnel, materials, equipment, supplies and services, and transportation related to placement-related activities.

(a) Clothing: The Department will place the BRS client with a BRS contractor and BRS provider with sufficient clothing at the time of placement. It is the responsibility of the BRS contractor and BRS provider to maintain the BRS client's clothing at an adequate and appropriate level. A caseworker may request approval from a child welfare supervisor or program manager for payment for additional clothing when necessary.

(b) Transportation: A BRS contractor and BRS provider are responsible to arrange or provide transportation for the BRS client for the following: school, to the extent not provided by the school district; medical, dental, and therapeutic appointments; recreational and community activities; employment; and shopping for incidental items. Notwithstanding this responsibility, the cost of transportation for the BRS client for the purposes of home visits or visits to foster homes or relatives will be equally shared by the Department, the BRS contractor and BRS provider and, in as much as they are able as determined by the Department, the BRS client's parents. The BRS contractor, BRS provider, and the caseworker must jointly plan the transportation method and payment procedures as much in advance as possible.

(3) Non BRS-Related Medical and Mental Health Care.

(a) If there is no record that the BRS client has received a physical examination within the six months immediately prior to the BRS client's placement with the BRS contractor and BRS provider, the BRS contractor and BRS provider must schedule a medical exam with the BRS client's caseworker, consistent with health insurance allowances, within 30 days of the BRS client's placement. The BRS contractor and BRS provider must keep documentation of the medical exam in the BRS client's file, and must send a copy to the BRS client's caseworker.

(b) The BRS contractor and BRS provider must coordinate with each BRS client's caseworker to ensure the BRS client's mental health, physical health (including alcohol and drug treatment services), dental, and vision needs are met. This does not include paying the cost of services or medications which are covered by the Oregon Health Plan (OHP) or by the BRS client's third party private insurance coverage. The BRS contractor and BRS provider must work with the BRS client's Department or Tribal caseworker to secure payment for services or medications not covered by OHP or the BRS client's third party private insurance coverage.

(c) The BRS contractor and BRS provider must administer and monitor medications consistent with all applicable Department rules in OAR 413-070-0400 through 413-070-0490, and the BRS provider's medication management policy must comply with Department rules.

(d) The BRS contractor and BRS provider must facilitate the BRS client's access to other medical and mental health providers whenever identified needs cannot be met within the scope of services offered by the BRS provider.

(4) Educational and vocational activities: A BRS contractor and BRS provider must have a system in place for a BRS client to attend school in order to meet the educational needs of a BRS client in its program either

on-site or at an off-site location that complies with OAR 413-100-0900 through 413-100-0940.

(5) Language and culture: The BRS contractor and BRS provider must allow a BRS client to speak his or her primary language and must honor his or her culture.

(6) Other placement-related activities (see OAR 410-170-0020):

(a) Recreational, social, and cultural activities:

(A) A BRS contractor and BRS provider must provide recreation time for the BRS client on a daily basis. A BRS contractor and BRS provider must offer activities that are varied in type to allow the BRS client to obtain new experiences.

(B) A BRS contractor and BRS provider must provide each BRS client a minimum of one opportunity per week to participate in recreational activities in the community, unless the BRS client is clearly unable to participate in offsite activities due to safety issues.

(C) The BRS contractor and BRS provider must provide access to or make available social and cultural activities for the BRS client. These activities are to promote the BRS client's normal development and help broaden the BRS client's understanding and appreciation of the community, arts, environment, and other cultural groups.

(D) The BRS contractor and BRS provider must not permit a BRS client to participate in recreational activities that present a higher level of risk to a BRS client without the approval of the Department. This applies to activities that require a moderate to high level of technical expertise to perform safely, present environmental hazards, or where special certification or training is recommended or required such as: whitewater rafting, rock climbing, ropes courses, activities on or in any body of water where a certified lifeguard is not present and on duty, camping, backpacking, mountain climbing, using motorized yard equipment, and horseback riding.

(b) Academic Assistance: If needed, the BRS contractor and BRS provider must provide adequate opportunities for the BRS client to complete homework assignments with assistance from staff, or a proctor foster home, if applicable.

(7) The BRS contractor and BRS provider must comply with OAR 413-010-0170 through 413-010-0185.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.116, 418.005
Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.116, 411.141, 418.005, 418.015, 418.027, 418.285, 418.312, 418.315, 418.490, 418.495
Hist.: CWP 10-2013, f. 11-14-13, cert. ef. 1-1-14; CWP 13-2015, f. & cert. ef. 8-4-15; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-090-0087
When a Child or Young Adult Placed with a BRS Program Is Missing

(1) When a child in care placed with a BRS program (see OAR 410-170-0020) is missing, the BRS contractor (see OAR 410-170-0020) must ensure its BRS providers immediately report information about the missing child in care to the Department.

(2) Documentation of the report required in section (1) of this rule is required as outlined in OAR 410-170-0030(12)(b)(B).

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.116, 418.005
Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.116, 411.141, 418.005, 418.015, 418.490, 418.495
Hist.: CWP 18-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 3-28-16; CWP 27-2015, f. 12-28-15, cert. ef. 1-1-16; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

413-090-0090
Compliance Reviews and Remedies

(1) The BRS contractor must comply with all federal and state laws and regulations required to be licensed as an approved foster care agency under OAR 413-215-0001 to 413-215-0131 and 413-215-0301 to 413-215-0396 or residential care agency under OAR 413-215-0001 to 413-215-0131 and 413-215-0501 to 413-215-0586.

(2) The BRS contractor (see OAR 410-170-0020) must cooperate, and ensure its BRS providers cooperate, with program compliance reviews or audits conducted by any federal, state or local governmental agency or entity related to the BRS program, including but not limited to the Department's provider rules OAR 407-120-0170, OAR 407-120-0180, OAR 407-120-0310, and OAR 407-120-1505.

(3) The Department or its designee will conduct compliance reviews periodically, including but not limited to review of documentation and onsite inspections.

(4) If the Department of Human Services becomes aware of any suspected, founded or substantiated abuse, deficiency, violation or failure to comply with the full compliance requirements of a contract, the Department of Human Services shall immediately investigate and take appropriate action, with primary concern given to the health, safety, and welfare of the children in care for whom the child-caring agency is responsible.

(5) Upon receiving any notices or reports related to compliance with a BRS contract, the BRS program office will investigate the report to determine whether there is any material breach of the terms of the contract and take appropriate contract action.

(6) The Department may pursue any combination of contract remedies, including but not limited to recovery of overpayments and other remedies authorized under the contract, at law or in equity against a BRS Contractor, a BRS Provider (see OAR 410-170-0020), or both, for non-compliance with applicable laws, regulations or contract provisions,. In addition to or in lieu of any of the above, the Department may proceed under the applicable provisions of OAR 410-170-0120.

Stat. Auth.: 409.050, 411.060, 411.070, 411.116 & 418.005
Stat. Implemented: 409.010, 411.060, 411.070, 411.116, 418.005, 418.027 & 418.495
Hist.: CWP 10-2013, f. 11-14-13, cert. ef. 1-1-14; CWP 11-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Implementation of SB 1515 (2016)
Adm. Order No.: CWP 12-2016(Temp)
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Adopted: 413-215-0000
Rules Amended: 413-215-0001, 413-215-0011, 413-215-0016, 413-215-0021, 413-215-0026, 413-215-0031, 413-215-0036, 413-215-0041, 413-215-0046, 413-215-0051, 413-215-0056, 413-215-0061, 413-215-0066, 413-215-0071, 413-215-0076, 413-215-0081, 413-215-0086, 413-215-0091, 413-215-0096, 413-215-0101, 413-215-0106, 413-215-0111, 413-215-0116, 413-215-0121, 413-215-0126, 413-215-0131, 413-215-0201, 413-215-0211, 413-215-0216, 413-215-0221, 413-215-0226, 413-215-0231, 413-215-0236, 413-215-0241, 413-215-0246, 413-215-0251, 413-215-0261, 413-215-0266, 413-215-0271, 413-215-0276, 413-215-0301, 413-215-0311, 413-215-0313, 413-215-0316, 413-215-0321, 413-215-0326, 413-215-0331, 413-215-0336, 413-215-0341, 413-215-0349, 413-215-0351, 413-215-0356, 413-215-0361, 413-215-0366, 413-215-0371, 413-215-0376, 413-215-0381, 413-215-0386, 413-215-0391, 413-215-0396, 413-215-0401, 413-215-0411, 413-215-0416, 413-215-0421, 413-215-0426, 413-215-0431, 413-215-0436, 413-215-0441, 413-215-0446, 413-215-0451, 413-215-0456, 413-215-0461, 413-215-0466, 413-215-0471, 413-215-0476, 413-215-0481, 413-215-0501, 413-215-0511, 413-215-0516, 413-215-0521, 413-215-0526, 413-215-0531, 413-215-0536, 413-215-0541, 413-215-0546, 413-215-0551, 413-215-0554, 413-215-0556, 413-215-0561, 413-215-0566, 413-215-0571, 413-215-0576, 413-215-0581, 413-215-0586, 413-215-0601, 413-215-0611, 413-215-0616, 413-215-0621, 413-215-0626, 413-215-0631, 413-215-0636, 413-215-0641, 413-215-0646, 413-215-0651, 413-215-0656, 413-215-0661, 413-215-0666, 413-215-0671, 413-215-0676, 413-215-0681, 413-215-0701, 413-215-0711, 413-215-0716, 413-215-0721, 413-215-0726, 413-215-0731, 413-215-0736, 413-215-0741, 413-215-0746, 413-215-0751, 413-215-0756, 413-215-0761, 413-215-0766, 413-215-0801, 413-215-0811, 413-215-0816, 413-215-0821, 413-215-0826, 413-215-0831, 413-215-0836, 413-215-0841, 413-215-0846, 413-215-0851, 413-215-0856, 413-215-0901, 413-215-0916, 413-215-0918, 413-215-0921, 413-215-0926, 413-215-0931, 413-215-0936, 413-215-0941, 413-215-0946, 413-215-0951, 413-215-0956, 413-215-0961, 413-215-0966, 413-215-0971, 413-215-0976, 413-215-0981, 413-215-0986, 413-215-0991, 413-215-0992, 413-215-0996, 413-215-1001, 413-215-1006, 413-215-1011, 413-215-1016, 413-215-1021, 413-215-1026, 413-215-1031
Rules Suspended: 413-215-0006, 413-215-0206, 413-215-0256, 413-215-0306, 413-215-0346, 413-215-0406, 413-215-0506, 413-215-0606, 413-215-0706, 413-215-0806, 413-215-0906, 413-215-0911
Subject: The Department of Human Services, Office of Child Welfare Programs, is amending rules in OAR chapter 413, division 215 to implement SB 1515 (Oregon Laws 2016, chapter 2016.) These rules govern the licensing and oversight of child-caring agencies by the Department. The rules are amended to reflect the new standards child-caring agencies must comply with to be licensed to provide

care or services to children. The rules are also amended to reflect new oversight responsibilities of the Department and new enforcement authority of the Department to take action on licensing violations and deficiencies. Primary rule changes include:

- Stating the standards child-caring agencies must comply with as provided in section 4 of SB 1515;
- Updating definitions to align with SB 1515, including "child in care," "child-caring agency," and "proctor foster home" and consolidating individual definitions rules into one overarching definitions rule;
- Requiring compliance with all applicable laws and rules, and the internal policies and procedures of the child-caring agency as a condition of licensure;
- Establishing new financial oversight requirements;
- Requiring child-caring agencies to have child abuse reporting policies, procedures, and training as required in section 37 of SB 1515;
- Clarifying requirements related to the internal written policies and procedures child-caring agencies must have;
- Requiring child-caring agencies to provide contact information for executive directors and board members and governmental agencies or units with whom they contract to provide services or care to children;
- Requiring child-caring agencies to provide access to children in care and the agencies' premises to Department personnel and other persons authorized in section 20 of SB 1515;
- Requiring child-caring agencies to provide the Department with information about children in its care and allow inspection of records and documents, including financial documents, when requested;
- Stating that the Department will investigate when it becomes aware that abuses, deficiencies, or failures to comply may be occurring in a child-caring agency;
- Updating the civil penalty criteria consistent with section 31 of SB 1515;
- Requiring annual inspections of premises where children reside or receive services;
- Granting new authority for the Department to take licensing enforcement actions when licensing violations exist;
- Requiring licensing enforcement actions in certain circumstances; and
- Making additional housekeeping changes to improve organization and update terminology.

The rule text showing proposed changes is available at http://www.dhs.state.or.us/policy/childwelfare/implement/temp_rules.htm.

Rules Coordinator: Kris Skaro—(503) 945-6067

413-215-0000
Definitions

Unless the context indicates otherwise, these terms are defined for use in OAR chapter 413, division 215:

(1) "Academic boarding school" means an organization or a program in an organization that:

(a) Provides educational services and care to children 24 hours a day; and

(b) Does not hold itself out as serving children with emotional or behavioral problems, providing therapeutic services, or assuring that children receive therapeutic services.

(2) "Adoption agency" means an organization providing any of the following services:

(a) Identifying a child for adoption and arranging an adoption.

(b) Securing the necessary consent to relinquishment of parental rights and to adoption.

(c) Performing a background study on a child or a home study on a prospective adoptive parent and reporting on such a study.

(d) Making determinations of the best interests of a child and the appropriateness of adoptive placement for the child.

(e) Monitoring a case after placement until final adoption.

(f) When necessary because of disruption before final adoption, assuming custody and providing childcare or other social services for the child pending an alternative placement.

(3) "Age-appropriate or developmentally appropriate activities" means:

(a) Activities or items that are generally accepted as suitable for children in care of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child in care based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and

(b) In the case of a specific child in care, activities or items that are suitable for the child in care based on the developmental stages attained by the child in care with respect to the cognitive, emotional, physical, and behavioral capacities of the child in care.

(4) "Approval" means acceptable to the regulatory authority based on conformity with generally recognized standards that protect public health.

(5) "Approved proctor foster parent" means an individual approved by a foster care agency to provide care to children in a proctor foster home.

(6) "Background check" means a check done in compliance with the Department's criminal records and abuse check rules, OAR 407-007-0200 to 407-007-0370.

(7) "Birth parent" means each person who holds a legally recognized parental relationship to the child but does not include the adoptive parents in the adoption arranged by the adoption agency.

(8) "Boarding" means care or treatment services provided on a 24 hour per day basis to children.

(9) "Child in care" means a person who is under 21 years of age who is residing in or receiving care or services from a child caring agency or proctor foster home.

(10) "Child-caring agency" is defined in ORS 418.205 and:

(a) Means any private school, private agency, or private organization providing:

(A) Day treatment for children with emotional disturbances;

(B) Adoption placement services;

(C) Residential care including, but not limited to, foster care or residential treatment for children;

(D) Outdoor youth programs; or

(E) Other similar care or services for children.

(b) Includes the following:

(A) A shelter-care home that is not a foster home subject to ORS 418.625 to 418.645;

(B) An independent residence facility as described in ORS 418.475;

(C) A private residential boarding school; and

(D) A child-caring facility as described in ORS 418.950.

(c) Child-caring agency does not include:

(A) Residential facilities or foster care homes certified or licensed by the Department under ORS 443.400 to 443.455, 443.830 and 443.835 for children receiving developmental disability services.

(B) Any private agency or organization facilitating the provision of respite services for parents pursuant to a properly executed power of attorney under ORS 109.056. For purposes of this paragraph, "respite services" means the voluntary assumption of short-term care and control of a minor child without compensation or reimbursement of expenses for the purposes of providing a parent in crisis with relief from the demands of ongoing care of the parent's child;

(C) A youth job development organization as defined in ORS 344.415;

(D) A shelter-care home that is a foster home subject to ORS 418.625 to 418.645; or

(E) A foster home subject to ORS 418.625 to 418.645.

(11) "Clinical supervisor" means a Qualified Mental Health Professional with two years post-graduate clinical experience in a mental health treatment setting. The clinical supervisor, as documented by the provider, operates within the scope of his or her practice or licensure, and demonstrates the competency to oversee and evaluate the mental health treatment services provided by other Qualified Mental Health Professionals or Qualified Mental Health Associates.

(12) "Contraband" means items the possession of which is prohibited by the child-caring agency including, but not limited to weapons or drugs.

(13) "Criminal history check" means compliance with the Department's criminal records history rules, OAR 407-007-0200 to 407-007-0370.

(14) "Day treatment" means a comprehensive, interdisciplinary, non-residential, community-based, psychiatric treatment, family treatment, and therapeutic activities integrated with an accredited education program provided to children with emotional disturbances.

(15) "Day treatment agency" means a child-caring agency that provides psychiatric day treatment services.

(16) "Debrief" means to interview a person (such as a child in care or staff member) usually upon return (as from an expedition) in order to obtain useful information.

(17) "Department" means the Oregon Department of Human Services.

(18) "Discipline" means a training process to help a child in care develop the self-control and self-direction necessary to assume responsibilities, make daily living decisions, and learn to conform to accepted levels of social behavior.

(19) "Disruption" means the interruption of an adoptive placement prior to the finalization of the adoption in a court of law.

(20) "Employee" means an individual holding a paid position with a child-caring agency.

(21) "Facility" means the physical setting, buildings, property, structures, administration, equipment, and program of a child-caring agency.

(22) "Family" means related members of a household, among whom at least one adult functions as a parent to one or more minor children.

(23) "Foster care agency" means a child-caring agency that offers to place children by taking physical custody of and then placing the children in homes certified by the child-caring agency.

(25) "Homeless or runaway youth" means a child in care who has not been emancipated by the juvenile court; lacks a fixed, regular, safe, and stable nighttime residence; and cannot immediately be reunited with his or her family.

(26) "Intercountry adoption" means an adoption in which a child who is a resident and citizen of one country is adopted by a citizen of another country.

(27) "Licensee" means a child-caring agency that holds a license issued by the Department.

(28) "Mass shelter" means a structure that contains one or more open sleeping areas in which, on a daily basis, only emergency services are provided to homeless or runaway youth, such as a meal and a safe place to sleep overnight.

(29) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance either internally or externally by any person.

(30) "Outdoor living setting" means an outdoor field setting in which services are provided to children in care either more than ten days per month for each month of the year or for longer than 48 hours at a location more than two hours from community-based medical services.

(31) "Outdoor youth program" means a program that provides, in an outdoor living setting, services to children in care who are enrolled in the program because they have behavioral problems, mental health problems, or problems with abuse of alcohol or drugs. "Outdoor youth program" does not include any program, facility, or activity operated by a governmental entity, operated or affiliated with the Oregon Youth Conservation Corps, or licensed by the Department as a child-caring agency under other authority of the Department. It does not include outdoor activities for youth designed to be primarily recreational.

(32) "Outdoor youth program activity" means an outdoor activity, provided to children in care for the purpose of behavior management or treatment, which requires specially trained staff or special safety precautions to reduce the possibility of an accident or injury. Outdoor youth activities include, but are not limited to: hiking, adventure challenge courses, climbing and rappelling, winter camping, soloing, expeditioning, orienteering, river and stream swimming, and whitewater activities.

(33) "Over the counter medication" means any medication that does not require a written prescription for purchase or dispensing.

(34) "Placement" means when the child is placed in the physical or legal custody of prospective adoptive parents.

(35) "Proctor foster home" means a foster home certified by a child-caring agency under Oregon Laws 2016, chapter 106, section 6 that is not subject to ORS 418.625 to 418.645.

(36) "Program" means a set of one or more services provided by a child-caring agency that make the child-caring agency subject to the rules in Division 413-215.

(37) "Re-adoption" means a process in which a child whose adoption was completed in another country is re-adopted in this country.

(38) "Reasonable and prudent parent standard" means the standard, characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child in care while encouraging the emotional and developmental growth of the child in care, that a substitute care provider shall use when determining whether to allow a child in care in substitute care to participate in extracurricular, enrichment, cultural, and social activities.

(39) "Residential" means care or treatment services provided on a 24 hour per day basis to children. For the purpose of these rules, "residential care or treatment" does not include services provided in family foster homes or adoptive homes.

(40) "Residential care agency" means a child-caring agency that provides services to children 24 hours a day.

(41) "Service plan" means an individualized plan of services to be provided to each child in care based on his or her identified needs and designed to help him or her reach mutually agreed upon goals. The service plan must address, at a minimum, the child in care's physical and medical needs, behavior management issues, mental health treatment methods, education plans, and any other special needs.

(42) "Shelter" means a facility operated by a child-caring agency that provides services for a limited duration to homeless or runaway youth.

(43) "Sole supervision" means being alone with a child in care or being temporarily the only staff in charge of a child in care or subgroup of children in care.

(44) "Special needs" mean a trait or disability of a child that requires special care or attention of the child or that historically has made placement of a child with similar characteristics or disability difficult.

(45) "Staff" means employees of the child-caring agency who are responsible for providing care, services, or treatment to a child in care.

(46) "Stationary outdoor youth program" means an outdoor youth program which remains in a stationary location that houses children in care.

(47) "Therapeutic boarding school" means an organization or a program in an organization that:

(a) Is primarily a school and not a residential care agency;

(b) Provides educational services and care to children for 24 hours a day; and

(c) Holds itself out as serving children with emotional or behavioral problems, providing therapeutic services, or assuring that children receive therapeutic services.

(48) "Transitional living program" means a set of services offered by a child-caring agency that provides supervision and comprehensive services for up to 18 months to assist homeless or runaway youth to make a successful transition to independent and self-sufficient living.

(49) "Wilderness first responder" means a medical training course and certification for outdoor professionals.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0001
Regulation of Child-caring Agencies

Except for a licensee subcontractor that provides limited services under OAR 413-215-0061(6)(b):

(1) A child-caring agency must have a license issued by the Department in accordance with Division 413-215. A licensee must at all times comply with the provisions of the license and with all laws (including rules) applicable to the child-caring agency.

(2) A child-caring agency may not represent itself as able to or purport to provide services governed by the rules in Division 413-215, except the services the child-caring agency is authorized by law (including rules) and licensed to provide.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0006
Definitions

As used in OAR 413-215-0001 to 413-215-0131:

(1) "Agency" means a private child-caring agency (under ORS 418.205(2)(a) and section (6) of this rule) or an organization or school that offers a residential program for children (regulated by ORS 418.327).

(2) "Child" means an unmarried person who is under 18 years of age.

(3) "Children" mean unmarried persons under 18 years of age.

(4) "Department" means the Oregon Department of Human Services.

(5) "Licensee" means a private child-caring agency or an organization or school that offers a residential program for children (regulated by ORS 418.327) and holds a license issued by the Department.

(6) "Private child-caring agency" is defined by the definitions in ORS 418.205, and means a "child-caring agency" that is not owned, operated, or administered by any governmental agency or unit.

(a) A "child-caring agency" means an agency or organization providing:

(A) Day treatment for disturbed children;

(B) Adoption placement services;

(C) Residential care, including but not limited to foster care or residential treatment for children;

(D) Outdoor youth programs (defined at OAR 413-215-0911); or

(E) Other similar services for children.

(b) A child-caring agency does not include residential facilities or foster care homes certified or licensed by the Department under ORS 443.400 to 443.455, 443.830 and 443.835 for children receiving developmental disability services.

(7) "Program" means a set of one or more services provided by an agency that make the agency subject to the rules in Division 413-215.

(8) "Substantial compliance" means a level of adherence to the rules in Division 413-215 and other applicable law that, although failing to meet one or more of the requirements of these rules, in the Department's estimation does none of the following:

(a) Constitute a danger to the health or safety of any individual.

(b) Constitute a willful or ongoing violation of the rights of children or families served by an agency.

(c) Prevent the accomplishment of the Department's purposes.

Stat. Auth.: ORS 409.050, 418.005, 418.240

Stats. Implemented: ORS 418.205 - 418.327

Hist.: CWP 29-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0011

Requirement to Obtain and Comply with License

Except for a licensee subcontractor that provides limited services under OAR 413-215-0061(6)(b):

(1) A child-caring agency must have a license issued by the Department in accordance with Division 413-215. A licensee must at all times comply with the provisions of the license and with all laws (including rules) applicable to the child-caring agency.

(2) A child-caring agency may not represent itself as able to or purport to provide services governed by the rules in Division 413-215, except the services the child-caring agency is authorized by law (including rules) and licensed to provide.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106

Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106

Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0016

Requirements Related to Corporation Status

(1) Only a corporation may receive a license from the Department under these rules (OAR 413-215-0001 to 413-215-0131). A limited liability company is an unincorporated association, and not a corporation, and may not be licensed under Division 413-215.

(2) In-state and out-of-state corporations must meet all requirements of the Oregon Secretary of State, Corporation Division in order to receive a license from the Department.

(3) A child-caring agency's articles of incorporation, its bylaws, or another written document approved by the board of directors must clearly set forth the purposes of the organization.

(4) A licensee must submit to the Department within seven business days each amendment to its articles of incorporation, bylaws, statement of its purposes, and name registration.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106

Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106

Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0050, CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0021

Governance

(1) Governing board requirements.

(a) A child-caring agency must have a governing board that has responsibility for its mission, operation, policy, and practices. These responsibilities must be stated in writing.

(b) The governing board of a child-caring agency must be a board of directors consisting of no fewer than five responsible individuals of good moral character who are citizens or legal residents of the United States.

(c) A child-caring agency must maintain a list of the members of the governing board that includes the name, address, telephone number, board office, and term of membership for each.

(d) Members of the governing board of a child-caring agency that is a not-for-profit agency may not receive compensation for serving on the board, other than reasonable reimbursement for the expenses associated with their services.

(2) Responsibilities of the governing board. The governing board of a child-caring agency must have all of the following responsibilities:

(a) To provide leadership for the child-caring agency.

(b) To be responsible for establishing the child-caring agency's by-laws and policies, to monitor the agency's programs consistent with its policies and mission, and to guide program development.

(c) To adopt by-laws that provide a basic structure for the operation of the programs of the child-caring agency.

(d) To develop by-laws for selection and rotation of its members.

(e) To ensure the employment of a qualified executive director and to delegate appropriate responsibility to that individual for the administration, management, and operation of the child-caring agency, including the employment of all child-caring agency staff and the authority to dismiss any staff member.

(f) To formally evaluate the executive director's performance annually.

(g) To approve the annual budget of anticipated income and expenditures necessary to provide the services described in its program description.

(h) To review an annual report of actual income and expenditures.

(i) To obtain and review an annual independent financial review of financial records.

(j) To establish and ensure compliance with personnel practices for the selection and retention of staff sufficient to operate the child-caring agency.

(k) To ensure a written quality improvement program that identifies systematic efforts to improve its services.

(l) To keep permanent records of meetings and deliberations on major decisions affecting the delivery of services.

(3) Executive director or program director requirements. A child-caring agency must operate under the direct supervision of an executive or program director appointed by the governing board. The executive director or program director must have all of the following qualifications:

(a) Knowledge of the requirements for providing care and treatment appropriate to the child-caring agency's programs.

(b) Ability to maintain records on children in care and families, personnel, and the child-caring agency in accordance with these rules.

(c) Ability to direct the work of staff.

(d) No history of conduct indicating it may be unsafe to allow the individual to supervise the care of children.

(e) Health sufficient to carry out the duties of the position.

(f) Good moral character, including honesty, fairness, and respect for the rights of others.

(4) The executive or program director must be responsible for all of the following:

(a) The daily operation and maintenance of the child-caring agency and its facilities in compliance with the rules in Division 413-215 and the established program budget.

(b) Administration of policies and procedures to ensure clear definition of staff roles and responsibilities, lines of authority, and equitable workloads that ensure safe and protective care, supervision, and treatment of the children served by the child-caring agency.

(c) Ensuring that only individuals whose presence does not jeopardize the health, safety, or welfare of the children in care served by the child-caring agency are employed or used as volunteers.

(d) Recruiting, employing, supervising, training, or arranging for training.

(e) Reporting to the governing board on the operation of the child-caring agency.

(f) Providing for appropriate staff to assume the executive or program director's responsibility for the operation and maintenance of the child-caring agency whenever the executive or program director is absent from the child-caring agency.

(g) Terminating from employment any staff member who is unsuitable or who performs in an unsatisfactory manner.

(h) Complying with all laws, and ensuring that all child-caring agency employees, contractors, and agents comply with all laws, including mandatory child abuse reporting laws.

(i) Ensuring that the child-caring agency, including its employees, contractors, and agents, complies with all licensing rules and regulations and internal policies and procedures of the child-caring agency.

(5) Suitability. In order for the Department to evaluate the suitability of a child-caring agency and its staff, the child-caring agency must immediately disclose to the Department all of the following information:

(a) Each instance in which the child-caring agency or a member of its staff or board of directors has permanently lost the right to provide services to children or families in any jurisdiction, and the basis for each action.

(b) The circumstances and disposition of any licensing denial, suspension, or revocation; or any other negative sanction or proposed sanction by an oversight body against the child-caring agency or a member of its staff or board of directors, if the denial, suspension, or revocation; or any other negative sanction or proposed sanction results from conduct that is relevant to the child-caring agency's, staff's, or board member's ability or fitness to carry out the duties imposed by these rules and governing statutes.

(c) For the previous ten years, any disciplinary action against or investigation of the child-caring agency or a member of its staff or board of directors by a licensing or accrediting body, including the basis and disposition of each action, if the disciplinary action or investigation results from conduct that is relevant to the agency's or staff's or board member's ability or fitness to carry out the duties imposed by these rules and governing statutes.

(d) Any instance in which the child-caring agency or a member of its staff or board of directors has been found guilty of any crime under federal, state, or foreign law.

(e) Any civil or administrative violation involving financial irregularities by the agency or a member of its staff or board of directors under federal, state, or foreign law.

(f) For the previous five years, any instance in which the child-caring agency, a member of its board of directors, or its executive or program director has filed for bankruptcy.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0060, CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0026
Financial Management

(1) Budget. A child-caring agency must operate under an annual line-item budget, showing planned expenditures and sources of income, which has been approved by the governing board as the plan for management of its funds, and provide a copy to the Department upon request.

(2) Funding. The annual budget of a licensee must document that the licensee has sufficient funds to meet the requirements of licensure, to operate the programs the licensee is licensed to operate, and to provide the services the licensee has stated the child-caring agency will provide.

(3) Fiscal accountability.

(a) A child-caring agency must maintain complete and accurate accounts, books, and records following generally accepted principles of accounting. A child-caring agency must provide to the Department current internal financial statements, general ledgers, bank statements, and any other financial records upon request.

(b) Beginning January 1, 2017, agencies with annual revenue in excess of $1,000,000 must provide annually to the Department:

(A) An annual audit completed by an independent certified public accountant who is not an employee of the child-caring agency and not otherwise affiliated with the child-caring agency and any financial statements or records submitted for purposes of that audit; and

(B) A tax compliance certificate issued by the Department of Revenue.

(c) Beginning January 1, 2017, agencies with annual revenue less than $1,000,000 must provide annually to the Department:

(A) An annual review conducted by an independent certified public accountant who is not an employee of the child-caring agency and not otherwise affiliated with the child-caring agency and any financial statements or records submitted for purposes of that review; and

(B) A tax compliance certificate issued by the Department of Revenue.

(4) A child-caring agency that is a non-profit corporation must comply with the requirements of ORS 128.610 to 128.769.

(5) Insurance. A child-caring agency must at all times maintain each of the following:

(a) General liability insurance in an amount that is reasonably related to the exposure to risk but in no case in an amount less than $1,000,000 for each occurrence and $3,000,000 aggregate.

(b) Adequate fire insurance.

(c) Adequate auto insurance if the child-caring agency owns or operates a vehicle.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0031
Cultural, Ethnic, and Gender-specific Services

A child-caring agency must make efforts, including attending available training, to ensure services provided to children in care and families are compatible with the cultural, ethnic, and gender considerations the children in care and families served by the child-caring agency consider important. The child-caring agency must ensure that written materials are made available in other languages as necessary, or as indicated by the demographic environment or the population served by the program.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0036
Conflict of Interest

A child-caring agency must have a conflict of interest policy that prohibits preferential treatment of board members, employees, volunteers, and contributors. The policy must outline safeguards when the child-caring agency allows dual relationships, such as employees serving as proctor foster parents, including the requirement that all material facts of the conflicted transaction and the direct or indirect interest of the board member, employee, volunteer, or contributor are disclosed or known to the board approving the conflicted transaction. If circumstances do not permit board approval of the conflicted transaction, a non-profit child-caring agency may obtain the approval of the Attorney General or the Department prior to entering into the transaction.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0041
Code of Ethics

If a child-caring agency subscribes to a code of ethics, or if the child-caring agency expects that all or some portion of its staff subscribe to a code of ethics, the child-caring agency must identify the code and make it available for review upon request.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0046
Children and Families Rights Policy and Grievance Procedures

(1) Rights of children in care and families served by the child-caring agency. A child-caring agency must guarantee the rights of children in care and the families the child-caring agency serves. A child-caring agency must enact and adhere to a policy ensuring those rights. A written copy must be distributed to all children in care and families served by the child-caring agency, and afford the following rights:

(a) The child in care's right to communicate with parents, legal guardians, legal representatives, or other persons approved for communication by the parent or legal guardian.

(b) The child in care's right to privacy.

(c) The child in care's right to participate in service planning.

(d) The child in care's right to fair and equitable treatment.

(e) The child in care's right to file a grievance if the child in care or family feels that they are treated unfairly or if they are not in agreement with the services provided.

(f) The child in care's right to have personally exclusive clothing

(g) The child in care's right to personal belongings.

(h) The child in care's right to an appropriate education.

(i) The child in care's right to participate in recreation and leisure activities.

(j) The child in care's right to have timely access to physical and behavioral health care services.

(2) Grievance Procedures.

(a) A child-caring agency must enact and adhere to written procedures for the children in care and families the child-caring agency serves to submit a grievance. The child-caring agency must provide the procedures to each child in care and family. The procedures must include all of the following:

(A) A process likely to result in a fair and expeditious resolution of a grievance.

(B) A prohibition of reprisal or retaliation against any individual who files a grievance.

(C) A procedure to follow, in the event the grievance is filed against the executive director, that ensures that the executive director does not make the final decision on the grievance.

(D) The name, address, and phone number of:

(i) A Department licensing coordinator; and

(ii) Any other governmental entities with oversight responsibilities.

(b) Grievances and complaints filed with the child-caring agency and all information obtained in their resolution must be maintained for a minimum of two years and provided to the Department upon request.

(3) A child-caring agency serving children in care who are also in Department care or custody must:

(a) Post and adhere to the Oregon Foster Children's Bill of Rights in accordance with the requirements of OAR 413-010-0180 and comply with ORS 418.200 to 418.202; and

(b) Have and adhere to a process for children in care in Department care or custody to make complaints consistent with ORS 418.201(1).

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0051
Resources Required

(1) A child-caring agency must ensure that it has sufficient safe space, equipment, and office equipment to deliver its services within Oregon.

(2) A child-caring agency must employ or contract for a sufficient number of competent and qualified employees to perform the functions regulated by these rules and to provide adequate care, safety, protection, and supervision of the children in care and families the child-caring agency serves.

(3) The child-caring agency must ensure that an individual who fulfills more than one staff function or position is trained for and meets the requirements for each position.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0056
Policies and Procedures

(1) For each program it is licensed to operate, a licensee must have and adhere to comprehensive policies and procedures that are well organized, accessible, and easy to use.

(2) The policies and procedures in section (1) of this rule must include a written policy on mandatory child abuse reporting, consistent with ORS 419B.005, 419B.010, and 419B.015 that includes requirements that agency employees, staff, contractors, agents, and proctor foster parents do all of the following:

(a) Immediately report suspected child abuse directly to the Department via the child abuse reporting hotline.

(b) Receive child-caring agency-provided training on mandatory abuse reporting requirements as part of employee orientation and at least annually thereafter as described in OAR 413-215-0061.

(c) Receive child-caring agency-provided training on the legal definition of child abuse in ORS 419B.005, and the definition of abuse that applies in child caring agencies as set forth in Oregon Laws 2016, chapter 106, section 36.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0061
Personnel

(1) Staff requirements and hiring. In order to ensure that the child-caring agency uses only staff and volunteers who do not jeopardize the health, safety, or welfare of children, a child-caring agency and its contractors must meet all of the following requirements:

(a) Comply with the Department's background check rules at OAR 407-007-0200 to 407-007-0370.

(b) Obtain reference checks.

(c) Employ individuals who meet the staff minimum qualifications as stated in the current job description.

(2) Personnel policies of the child-caring agency and its contractors must include all of the following:

(a) For each staff position, a job title and a written job description that defines the qualifications, duties, and lines of authority for the position.

(b) A staff development plan providing for opportunities for professional growth through supervision, training, and experience.

(c) Procedures for a written annual evaluation of the work and performance of each staff member that include provision for employee participation in the evaluation process.

(d) A description of the termination procedures established for resignation, retirement, and dismissal.

(e) A written grievance procedure for staff.

(3) Personnel Files. The child-caring agency and its contractors must have a personnel file for each employee that is maintained for a minimum of two years after the termination date of each employee and includes all of the following:

(a) A record of education, training, and previous employment.

(b) Documentation of reference checks.

(c) Documentation that a background was completed as required in OAR 407-007-0200 to 407-007-0370.

(d) Annual performance evaluations.

(e) Ongoing record of training received.

(f) Records of personnel actions.

(g) Starting and termination dates, and reason for termination.

(h) A current job description.

(4) Staff orientation. A child-caring agency must provide orientation to each newly hired employee within 30 days of employment on all of the following subjects:

(a) Child-caring agency policies and procedures.

(b) Ethical and professional guidelines.

(c) Organizational lines of authority.

(d) Attributes of population served.

(e) Child-abuse reporting laws and requirements including the definition of abuse that applies specifically to a child in care.

(f) Privacy laws.

(g) Emergency procedures.

(5) Child abuse reporting training: A child-caring agency must provide training and written materials on mandatory child abuse reporting responsibilities to all employees and, if applicable, proctor foster parents as part of initial orientation and annually thereafter. The training must include written instruction on the following:

(a) The legal definition of child abuse in ORS 419B.005 and the definition of abuse that applies in child-caring agencies as set forth in Oregon Laws 2016, chapter 106, section 36;

(b) The legal responsibility to immediately report suspected child abuse or neglect by calling the appropriate child abuse reporting hotline; and

(c) The legal responsibility to report child abuse is personal to the employee and, if applicable, the approved proctor foster parent and is not fulfilled by reporting the child abuse or neglect to the owner, operator, or any other employee of the child-caring agency even if the owner, operator, or other employee reports the child abuse to the Department.

(6) Contractor-related requirements.

(a) If a child-caring agency contracts with other private providers or individuals in lieu of or in addition to hiring permanent employees, the child-caring agency must ensure that the contractor meets the applicable requirements of this rule and the rules in Division 413-215 specific to the type of service the contractor provides.

(b) If the child-caring agency contracts to provide any of its services:

(A) The child-caring agency must ensure the contractor has a process to screen its employees for professional conduct and sufficient methods for holding its employees accountable.

(B) The contract between the child-caring agency and contractor must specify all of the following:

(i) The services the contractor provides.

(ii) The contractor's fees.

(iii) Disclosure of information from the contractor to the agency.

(iv) Lines of authority between the contractor and the child-caring agency and among employees of the contractor in connection with the provision of services.

(v) Adherence to applicable Department rules and requirements, including, but not limited to the background check rules in OAR 407-007-0200 to 407-007-0370.

(vi) Any liability of the child-caring agency for acts of the contractor, any rights of indemnity, and any limitations on liability of the child-caring agency or contractor.

(C) The child-caring agency must amend any contracts that started prior to the effective date of this rule to comply with this rule.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106

Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0070, CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0066
Privacy

(1) A child-caring agency must have and follow a written policy that addresses protection of the privacy of children and families the child-caring agency serves or has served.

(2) Except as provided section (4) of this rule, a child-caring agency may not disclose any identifying information of a child in care, including a picture, without first obtaining the written consent from the child's parents or legal guardians.

(3) A child-caring agency must ensure the privacy of all information that identifies a child in care or family the child-caring agency serves. A child-caring agency may not disclose such information without proper written consent or as otherwise allowed by law.

(4) A person making a report of abuse as required in ORS 419B.010 and Oregon Laws 2016, chapter 106, section 37, may include references to otherwise confidential information for the sole purpose of making the report.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0071
Records and Documentation

With respect to the records on children in care and families a child-caring agency serves and to other records maintained by a child-caring agency, the child-caring agency must meet all of the following requirements:

(1) The child-caring agency must accurately prepare and safely store its records and ensure the records are readily available for inspection by the Department.

(2) All entries in records required by the rules in Division 413-215 must be permanent, legible, dated, and signed by the person making the entry.

(3) Records must be uniform in organization, readily identifiable and accessible, current and complete, and contain all of the information required of the child-caring agency by the rules in Division 413-215.

(4) Records must be corrected, when necessary, by the use of a single line drawn through the incorrect information, the addition of the correct information, a notation of the date the correction is made, and the initials of the person making the correction. No "white out," eraser tape, or other means of eradicating information may be used to make a change to a record.

(5) Fiscal records must be kept that are accurately prepared and properly reflect all direct and indirect revenues and expenditures for the operation and maintenance of the child-caring agency.

(6) The child-caring agency must keep reports of all inspections of the child-caring agency and its facilities for not less than five years after an inspection.

(7) The child-caring agency must maintain a permanent registry of each child in care the child-caring agency serves. The registry must include the child in care's name, gender, and birth date; the names and addresses of his or her parents or guardians; the dates of admission; and the placement upon discharge.

(8) If a child-caring agency changes ownership or executive or program director, all records of the children in care and families served by the child-caring agency must remain in a facility operated by the child-caring agency.

(9) Prior to the dissolution of a child-caring agency, the executive or program director must inform, in writing, a Department licensing coordinator of the location and storage of records on children in care or that the records have been transferred with the children in care to a new facility.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0140, CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0076
Discipline and Behavior Management (Excluding Adoption Agencies)

(1) A child-caring agency except a child-caring agency licensed only to provide adoption services under OAR 413-215-0401 to 413-215-0481 must meet all of the requirements of this rule.

(2) Discipline Policy.

(a) A child-caring agency must incorporate into the program's caregiving practices positive non-punitive discipline and ways of helping a child in care build positive personal relationships, self-control, and self-esteem.

(b) The discipline policy must prohibit all of the following:

(A) Spanking, hitting, or striking with an instrument.

(B) Committing an act designed to humiliate, ridicule, or degrade a child in care or undermine the self-respect of a child in care.

(C) Punishing a child in care in the presence of a group or punishment of a group for the behavior of one child in care.

(D) Depriving a child in care of food, clothing, shelter, bedding, rest, sleep, toilet access, or parental contact.

(E) Assigning extremely strenuous exercise or work or requiring a child in care to spend prolonged time in one position likely to produce unreasonable discomfort.

(F) Using physical restraint (see paragraph (3)(e)(A) of this rule) or seclusion as discipline.

(G) Permitting or directing a child in care to punish another child in care.

(H) Using any other kind of harsh punishment.

(I) Denying a parent, guardian, or sibling the right to visit a child in care solely as a disciplinary measure against the child in care.

(3) Behavior Management.

(a) The child-caring agency must have and follow behavioral management policies consistent with the requirements of this rule. Copies of the policies shall be provided to the Department annually and at any time that they are adopted, amended, or deleted.

(b) The behavior management policy of the child-caring agency must identify appropriate and positive methods of behavior management based on a child's needs, developmental level, and behavior.

(c) The policies must include a description of the model, program, or techniques used and its use of each of the following:

(A) Non-violent crisis intervention. For purposes of this rule, "non-violent crisis intervention" means a nationally recognized, holistic system for defusing escalating behavior and safely managing physically aggressive behavior. The agency's choice of a "non-violent crisis-intervention system" must be conveyed to and approved by the Department.

(B) Use of time out, if applicable.

(C) Use of restraints, if applicable.

(i) Chemical restraint, meaning the administration of medication for the management of uncontrolled behavior, is prohibited. Chemical restraint is different from the use of medication for treatment of symptoms of severe emotional disturbances or disorders

(ii) Mechanical restraint, meaning the use of any physical device to involuntarily restrain the movement of a child in care as a means of controlling his or her physical activities, is prohibited.

(D) Use of seclusion, if applicable.

(d) Time out.

(A) For the purpose of this rule, "time out" means restricting a child in care to a designated area for a period of time to give the child in care an opportunity to regain self-control.

(B) "Time out" must include frequent contact with staff.

(C) Rooms used for "time out" must have adequate space, heat, light, and ventilation, and must not be capable of locking.

(D) "Time out" episodes must be documented in the child in care's clinical record.

(e) Physical restraint.

(A) For the purposes of this rule, "physical restraint" means the act of restricting a child in care's voluntary movement as an emergency measure in order to manage and protect the child in care or others from injury when no alternate actions are sufficient to manage the child in care's behavior. "Physical restraint" does not include temporarily holding a child in care to assist him or her or assure his or her safety, such as preventing a child in care from running onto a busy street.

(B) Only child-caring agency staff and proctor foster parents who have been trained in a nationally recognized non-violent crisis-intervention system may use physical restraint and only when physical restraint is necessary as a last resort to prevent a child in care from inflicting harm to self or others.

(C) The child-caring agency must report each use of physical restraint on a child in care to the child in care's parent or legal guardian, caseworker, or probation officer within five working days, and must document the notification in the child in care's case file.

(D) Any use of physical restraint by a staff member of the child-caring agency, if the member is not trained in a nationally recognized non-violent crisis intervention system, must also be reported to a Department licensing coordinator within one working day of occurrence.

(E) Limitations. The child-caring agency must have a policy that prohibits the application of a non-violent physical restraint to a child in care who has a documented physical condition that would contraindicate the use of that particular restraint, unless a qualified medical professional has previously and specifically authorized its use in writing for that child in care. Documentation of the authorization must be maintained in the child in care's record.

(F) Physical Restraint Documentation. The policies of the child-caring agency must require a report on an incident report form of behavior that required the use of physical restraint. The report must include the specific attempts to de-escalate the situation before using physical restraint and the length of time the physical restraint was applied. The report must include the time the restraint started and the time it was terminated, the debriefing completed with the staff and child in care involved in the physical restraint, and documentation of a review by the executive director, program director, or designee.

(G) Review. The policies of the child-caring agency must require that whenever a physical restraint is used on a child in care more than two times in seven days, there is a review by the executive director, the director's designee, or a management team to determine the suitability of the program for the child in care, whether modifications to the child in care's plan are warranted, and whether staff need additional training in alternative therapeutic behavior management techniques. The child-caring agency must take appropriate action indicated by the review.

(f) Seclusion.

(A) For the purposes of this rule, "seclusion" means that a child in care is involuntarily confined to an area or room, and is physically prevented from leaving.

(B) Rooms used for seclusion must have adequate space, heat, light, and ventilation.

(C) Seclusion may only be used to ensure the safety of the resident or others during an emergency safety situation.

(D) Episodes of seclusion are limited to two hours for children in care age nine and older and one hour for children in care under the age of nine.

(E) Visual monitoring of a child in care in seclusion must occur and be documented at least every fifteen minutes.

(F) Each incident of seclusion must be documented in the child in care's clinical record, and must include the clinical justification for its use.

(G) If incidents of seclusion used with an individual child in care cumulatively exceed five hours in five days, or a single episode of more than two hours for children in care age nine and older or more than one hour for children in care under age nine, the executive director or designee must review the case with those with clinical leadership responsibilities to evaluate the child in care's plan of care and make necessary adjustments.

(4) If the child-caring agency utilizes seclusion and restraint as part of its behavior management practices, its use of seclusion and restraint must be in compliance with all applicable federal and state regulations and rules.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0190, CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0081
Application for License

(1) For purposes of this rule, "applicant" means a child-caring agency that is in the process of applying for a license from the Department.

(2) Application required.

(a) A child-caring agency must submit a completed application in each of the following situations:

(A) To obtain an initial license.

(B) To renew a license.

(b) An applicant must apply for a license on forms provided by the Department.

(3) Documents to be submitted by a new applicant. The applicant must submit to the Department at the time of application all of the following documents:

(a) An application form that is complete and signed by the board chair and either the executive director or program director.

(b) A copy of the articles of incorporation, bylaws, amendments to the articles of incorporation and bylaws, and documents evidencing each name change or assumed business name.

(c) A list of the current board of directors, including names, addresses, telephone numbers, email addresses, term, and office held.

(d) A complete personnel list with job titles.

(e) An organization chart with job titles and staff names.

(f) Authorization to obtain criminal histories and child abuse background checks in accordance with these rules on the executive director and program director.

(g) A proposed annual budget adequate to finance the program. The budget must clearly indicate all sources of income and anticipated expenditures, as described in OAR 413-215-0026.

(h) A written program description, including admission requirements, population served, gender and ages served, types of programs and services offered, the cost to clients (if any), the geographical area to be served, and the projected staffing pattern. The program description must identify all exclusions that would make a child in care ineligible to be served by the child-caring agency.

(i) For new, expanding, or changing residential programs only, documentary proof of compliance with ORS 336.575, which requires notification of the superintendent or the district school board of possible effect of additional children in care and services, three months before children in care arrive at the agency's facility.

(j) Current copies of all written policies and procedures required by these rules including:

(A) A written policy on conflict of interest that meets the requirements of OAR 413-215-0036.

(B) Written policies regarding the rights of children and families the child-caring agency would serve upon being licensed that meets the requirements of OAR 413-215-0046.

(C) A grievance procedure for children in care and families that meets the requirements of OAR 413-215-0046.

(D) A written policy on mandatory child abuse reporting that meets the requirements of OAR 413-215-0056.

(E) A written policy regarding personnel that meets the requirements of OAR 413-215-0061.

(F) A written privacy policy that meets the requirements of OAR 413-215-0066.

(G) A written discipline and behavior management policy that meets the requirements of OAR 413-215-0076.

(H) A written policy for compliance with Interstate Compact on the Placement of Children (ICPC) (see ORS 417.200 to 417.260), if applicable.

(I) A written policy for compliance with the Indian Child Welfare Act of 1978, Pub. L. No. 95-608, 92 Stat. 3069 (1978) (ICWA) (see OAR 413-070-0100 to 413-070-0260), if applicable.

(k) Floor plans for any proposed facility.

(l) Proof of adequate fire, auto, and liability insurance.

(m) Emergency procedures.

(n) Current inspection report of the Fire Marshal and current sanitation inspection reports, unless the application is for a license as an adoption agency or a foster care agency. For an outdoor youth program, these inspections reports are only required for each base camp component.

(o) For the previous ten years, a copy of each report by a federal or state authority concerning a criminal charge, charge of child abuse, malpractice complaint, or lawsuit against the child-caring agency, a member of the child-caring agency's board of directors, or one of its employees related to the provision of services, and the basis and disposition of each action, if applicable.

(p) A list of governmental agencies or units with whom the child-caring agency contracts to provide care or services to a child. This list must include a brief description of the care or services to a child provided under the contract and the name, mailing address, telephone number, and email address for the contact person for the governmental agency or unit with whom the child-caring agency holds the contract.

(q) Other documents or information requested by the Department.

(4) Documents to be submitted to renew a license. A licensee must submit to the Department at the time of application for renewal all of the following documents:

(a) An application renewal form that is complete and signed by the board chair and either the executive director or program director.

(b) A list of the current board of directors, including names, addresses, telephone numbers, email addresses, term, and office held.

(c) A complete personnel list with job titles.

(d) An organization chart with job titles and staff names.

(e) Authorization to obtain background checks in accordance with these rules on the executive director and program director.

(f) Proof of adequate fire, auto, and liability insurance.

(g) Current inspection report of the Fire Marshal and current sanitation inspection reports, unless the re-application is for a license as an adoption agency or a foster care agency. For an outdoor youth program, these inspections reports are only required for each base camp component.

(h) Annual financial statements and records as described in OAR 413-215-0026.

(i) A tax compliance certificate issued by the Oregon Department of Revenue.

(j) Policies required in subsection (3)(j) of this rule.

(k) A list of governmental agencies or units with whom the child-caring agency contracts to provide care or services to a child. This list must include a brief description of the care or services to a child provided under the contract and the name, mailing address, telephone number, and email address for the contact person for the governmental agency or unit with whom the child-caring agency holds the contract.

(l) Other documents or information requested by the Department.

(5) Application fees.

(a) The Department requires no fee to be paid by an applicant for the inspection conducted to determine whether to grant, withhold, suspend, or revoke a license required by these rules.

(b) child-caring agency may be required to pay for inspections done by other governmental agencies, such as county health departments and the State Fire Marshal, that are necessary to obtain a license from the Department.

(6) Processing the Application. Within 30 days of the receipt of an application and the documents described in section (3) or (4) of this rule, the Department will begin its review to determine whether the applicant is or will be in compliance with the rules in Division 413-215 and whether denial is required or appropriate under OAR 413-215-0121. In connection with its evaluations, the Department may examine the records and files of the applicant, inspect and observe the physical premises, and interview children and families served by the program, the staff of the applicant, and persons in the community.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0020, CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0086
Issuance of License

(1) If the Department determines from the application and its review that the child-caring agency is or will be in compliance with the rules in Division 413-215 and that denial is not required or appropriate under OAR 413-215-0121, the Department issues a license to the child-caring agency. A license is effective for a two-year period subject to being suspended, revoked, or rendered invalid when not utilized for a period of six consecutive months as provided in OAR 413-215-0121.

(2) The license is not transferable and is not applicable to an entity other than the corporation to which the license is issued. The license is applicable only to a facility or site identified on the license.

(3) The following information is included on the license:

(a) The incorporated name of the licensee and its "assumed business name" if applicable.

(b) The address of the administrative office of the corporation.

(c) The address of each facility operated under authority of the license.

(d) The maximum number to be served at any one time in each facility, if applicable.

(e) The age and gender of the persons to be served by the child-caring agency.

(f) The types of services the licensee is authorized to provide.

(g) The effective date and term of the license.

(h) Restrictions or conditions imposed by the Department, if applicable.

(i) Such other information deemed appropriate by the Department.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08: CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0091
Responsibilities of Licensees

A licensee is responsible to do all of the following:

(1) Ensure that children in care are well cared for and safe from self-harm, physical harm, and abuse from others.

(2) Adhere to and comply with all policies and procedures of the licensee and ensure that the licensee's employees and volunteers adhere to and comply with the licensee's policies and procedures.

(3) Comply with all federal, state, and local laws, rules, regulations, executive orders, and ordinances applicable to the licensee and ensure that the licensee's employees and volunteers comply with all federal, state, and local laws, rules, regulations, executive orders, and ordinances applicable to the licensee.

(4) Meet with an employee of the Department upon request and make all employees, staff, agents, and contractors available to meet with the Department upon request.

(5) Notify the Department if the child-caring agency employs a new executive director or a new manager of an individual facility or program and when a new board chairman or member of the governing board is appointed, including names, mailing addresses, email addresses, and phone numbers.

(6) Provide copies of all written policies and procedures required in OAR 413-215-0081(3)(j) when requested.

(7) Make reports to the Department as required by these rules and upon request to ensure that the requirements for licensing are met.

(8) Provide information about children in care when requested by the Department and as required by OAR 413-215-0026. The Department may request information about children in care at any time. Information requested may include, but is not limited to, the following:

(a) Names;

(b) Dates of birth;

(c) Dates of admission or service delivery;

(d) Names and contact information for children's parents or guardians;

(e) Address where children reside or receive services;

(f) Assessments and diagnostic information;

(g) Treatment and service records;

(h) Medical records;

(i) Case notes; and

(j) Incident reports.

(9) Provide the Department with financial records and documents when requested by the Department. Records and documents requested by the Department may include, but are not limited to, the following:

(a) Annual operating budget;

(b) Annual financial statements;

(c) Tax returns and tax-related documentation;

(d) Tax compliance certificates issued by the Oregon Department of Revenue; and

(e) Signed releases authorizing the Department to obtain financial information about the child-caring agency from the Internal Revenue Service, the Department of Revenue, or any other government entity.

(10) Provide the Department with any completed proctor foster home studies as required in OAR 413-215-0321(3) upon request.

(11) Permit immediate access to a child in care and access to any area of the premises in which the child in care receives care or services to the following:

(a) Employees and representatives of the Department;

(b) The child in care's attorney;

(c) The child in care's court-appointed special advocate;

(d) The parent or legal guardian of the child in care if the child in care has not been committed to the custody of the Department or the Oregon Youth Authority;

(e) Any governmental agency or unit that has a contract with the child-caring agency to provide care or services to the child in care; and

(f) Any other person authorized by the Department.

(12) Notify a Department licensing coordinator within one business day if a critical event occurs. As used in this section, a "critical event" is a significant event occurring in the operation of a child-caring agency that is considered likely to cause complaints, generate concerns, or come to the attention of the media, law enforcement agencies, first responders, Child Protective Services, or other regulatory agencies. Compliance with this notification requirement does not satisfy the mandatory reporting requirements under ORS 419B.005 to 419B.045.

(13) Notify a Department licensing coordinator when information required in OAR 413-215-0081(3)(p) relating to governmental agencies or units with whom the child-caring agency contracts to provide care or services to a child changes.

(14) Notify a Department licensing coordinator 30 days or more prior to the voluntary closure or change to inactive status of a program of the child-caring agency.

(15) Post a copy of the license in a common area at each facility operated by the licensee and retain the license at the administrative offices of the licensee.

(16) Return the license to a Department licensing coordinator immediately upon the suspension or revocation of the license, a change to inactive status, or a change of ownership or location.

(17) Notify a Department licensing coordinator of the discontinuation of services or the intent to reactivate a service after a period of inactivity.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08, CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0096
Renewal of License

(1) To renew a license, a licensee must submit to the Department an application for renewal prior to the expiration of the current license (see OAR 413-215-0081). If the Department receives an application for renewal before the license expires, the license remains effective until the Department issues a decision on the application.

(2) Before the Department will consider an application for renewal of a license, the licensee must submit the documents required in OAR 413-215-0081(4) with an application to renew a license. The licensee must make available for examination by the Department all records and files of the child-caring agency. The licensee must allow representatives of the Department to enter and inspect the physical premises, and interview children receiving services from the child-caring agency and child-caring agency staff.

(3) Within 30 days of the receipt of the renewal application, the Department will begin its review to determine whether the licensee is or will be in compliance with the rules in Division 413-215 and whether denial is required or appropriate under OAR 413-215-0121.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0230, CWP 29-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0101
Periodic Inspections

(1) The Department will visit and inspect each licensee and each facility operated by the licensee to determine whether the program is maintained and operated in accordance with the rules in Division 413-215 and all other applicable laws and rules.

(a) The Department will inspect premises where children in care reside and receive services from employees or staff who do not reside on the premises at least once per year. These unannounced inspections will occur at unexpected times and at irregular intervals.

(b) The Department will inspect premises not covered under subsection (a) of this section at least once every two years.

(2) Employees of the Department may conduct inspections and may visit the licensee at unannounced, irregular intervals.

(3) The Department may also make informal visits, with notice to the licensee, in order to provide technical assistance to the licensee.

(4) A licensee must allow employees of the Department, for the purposes of carrying out the inspections and investigations described in OAR Divisions 407-045, 413-015, 413-090, and 413-215 and other applicable rules, to enter the facilities of the child-caring agency; inspect all accounts, records of work, and physical premises; and interview all children and staff.

(5) A child-caring agency must make all of the following documents available for review during a site inspection:

(a) Personnel files on each employee.

(b) Criminal history, child abuse, and reference checks on volunteers.

(c) Board meeting minutes.

(d) A complete set of the policies and procedures of the child-caring agency.

(e) Records of the children and families served by the child-caring agency.

(f) Other documents or information requested by the Department.

(6) A licensee must allow access by the State Fire Marshal or an authorized representative of the State Fire Marshal to all facilities maintained by the licensee, residents of its facilities, and records of the licensee that pertain to fire safety.

(7) A licensee must allow access by a registered sanitarian, for the purpose of conducting a health and sanitation inspection, to the facilities maintained by the child-caring agency, the records of the child-caring agency pertaining to sanitation, and residents.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0210, CWP 29-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0106
Investigation of Complaints

(1) A child-caring agency must cooperate fully and comply with all investigations by the Department conducted pursuant to the requirements of the law.

(2) The Department will immediately investigate and take appropriate action when the Department becomes aware that any suspected or founded abuses, deficiencies, violations, or failures to comply with the full compliance requirements described in ORS 418.240 and these rules are occurring in a child-caring agency.

(3) The Department will immediately investigate when the Department becomes aware that a child-caring agency, or an owner, operator, or employee of a child-caring agency, is the subject of an investigation by another state, federal, or law enforcement agency and take action as provided in Oregon Laws 2016, chapter 106, section 4.

(4) Upon determination of a level of threat or risk to children in care, the Department will take appropriate steps to protect and ensure the health, safety, and welfare of children in care.

(5) The Department will notify the executive director and board of directors of any action the Department may initiate as a result of the investigation, and of the deadlines for the child-caring agency to complete any corrective action.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0220, CWP 29-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0111
Corrective Actions

(1) As a result of an inspection, or at any time, the Department may require a child-caring agency to comply with a plan of correction that explains the actions required to be taken by the child-caring agency to be in compliance with the rules in Division 413-215 and other applicable statutes and rules.

(2) The Department may establish deadlines by which the child-caring agency must correct the deficiencies noted in the corrective action plan.

(3) The Department may impose conditions on a license as provided in OAR 413-215-0121 while corrections are pending.

(4) When a condition exists that seriously endangers or places at risk the health, safety, or welfare of a child in care, the Director of the Department will issue an interim emergency order without notice, or with reasonable notice under the circumstances, requiring the child-caring agency to correct the conditions and ensure the safety of children in care of the child-caring agency. The interim emergency order remains in force until a final order, after a hearing, is entered in accordance with ORS chapter 183.

(5) The director may commence an action to enjoin operation of a child-caring agency:

(a) If the child-caring agency is being operated without a license; or

(b) If the child-caring agency fails to comply with a plan of correction imposed by the Department or an interim emergency order issued under section (4) of this rule within the time specified in the order.

(6) In addition to the corrective actions in this rule and other rules in Division 413-215, the Department may take any other lawful actions necessary to protect and ensure the health, safety, and welfare of children in care as necessary under the circumstances.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0116
Civil Penalties

(1) In addition to the actions described in OAR 413-215-0121, as provided in ORS 418.992 and Oregon Laws 2016, chapter 106, section 31, the Department may impose a civil penalty against a child-caring agency if the child-caring agency has committed one of the following acts:

(a) Violation of any of the terms or conditions of a license, certification, or other authorization issued under ORS 418.205 to 418.327, 418.470, 418.475, or 418.950 to 418.970.

(b) Violation of any rule in division 413-215 or a general order of the Department against a child-caring agency.

(c) Violation of any final order of the Department that pertains specifically to the child-caring agency.

(d) Violation of the requirement to have a license, certificate, or other authorization under ORS 418.205 to 418.327, 418.470, 418.475, or 418.950 to 418.970.

(2) The Department will by law impose a civil penalty not to exceed $500, unless otherwise required by law, on any child-caring agency for falsifying records, reports, documents, or financial statements or for causing another person to do so.

(3) The Department will by law impose a civil penalty of not less than $250 nor more than $500, unless otherwise required by law, on a child-caring agency or child-care facility that assumes care or custody of, or provides care or services to, a child in care knowing that the child in care's care needs exceed the license, certificate, or authorization classification of the child-caring agency if the assumption of care or custody, or provision of care or services, places the child in care's health, safety, or welfare at risk.

(4) As required by ORS 418.995, the Department will consider the following factors in making a decision about the level of penalty imposed:

(a) The past history of the child-caring agency incurring the penalty in taking all feasible steps or procedures necessary or appropriate to correct any violation.

(b) Any prior violations of statutes or rules pertaining to the child-caring agency.

(c) The economic and financial conditions of the child-caring agency incurring the penalty.

(d) The immediacy and extent to which the violation threatens or places at risk the health, safety, and well-being of the children in care served by the child-caring agency.

(5) Civil Penalty Schedule. Except as provided otherwise in sections (2) and (3) of this rule, for each violation by the child-caring agency, the following civil penalty may be imposed:

(a) $100 per violation if all four subsections of section (4) of this rule favor the child-caring agency.

(b) $200 per violation if three subsections of section (4) of this rule favor the child-caring agency.

(c) $300 per violation if two subsections of section (4) of this rule favor the child-caring agency.

(d) $400 per violation if one subsection of section (4) of this rule favor the child-caring agency.

(e) $500 per violation if no subsections of section (4) of this rule favor the child-caring agency.

(6) Unless the health, safety, or welfare of a child in care is at risk, in cases in which the Department is considering the imposition of a civil penalty, the Department will prescribe a reasonable time period for the child-caring agency to eliminate the violation:

(a) Not to exceed 45 days after the first notice of violation; or

(b) In cases where the violation requires more than 45 days to correct, such time as is specified in a plan of correction found acceptable by the Department.

(7) Unless otherwise required by law, a civil penalty imposed under this rule may be canceled or reduced under terms or conditions determined by the Department to be proper and consistent with public health and safety.

(8) A civil penalty will be imposed by written notice of violation and assessment of penalty provided to the child-caring agency. Such notice shall be sent by registered or certified mail and will include:

(a) Reference to the statute, rule, standard, or order involved;

(b) A short statement of the matters asserted or charged;

(c) A statement of the amount of the penalty imposed; and

(d) A statement of the right of the child-caring agency to request a hearing.

(9) As provided in ORS 418.993, the child-caring agency to which the notice of violation and assessment of penalties is addressed has 10 days from the date of service of the notice in which to make a written request for a hearing. All such hearings shall be conducted as a contested case hearing pursuant to the applicable provisions of ORS 183.413 to 183.470.

(10) A civil penalty imposed under this rule is due and payable 10 days after the order imposing the civil penalty becomes final by operation of law or on appeal. A child-caring agency against whom a civil penalty is to be imposed shall be served a notice in the form provided in ORS 183.415. Service of the notice shall be accomplished in the manner provided in ORS 183.415.

(11) If the child-caring agency does not request a hearing, or if after such a hearing the child-caring agency is found to be in violation of a license, rule or order as specified in the notice, the Department will make a final order imposing the penalty.

(12) Judicial review of civil penalties shall be as provided under ORS 183.480. The reviewing court may, in its discretion, reduce the amount of the penalty.

(13) Civil penalties are payable within 10 days after the order of the Department is entered, unless the order is appealed and is sustained or modified, in which case the penalty is payable within 10 days after the court decision is rendered.

(14) If the order of civil penalty is not appealed or sustained on appeal, and the amount of penalty is not paid within 10 days after the order becomes final, the order may be recorded with the county clerk in any county of this state. The clerk shall thereupon record the name of the child-caring agency incurring the penalty and the amount of the penalty in the County Clerk Lien Record.

(15) Upon recording an order in the County Clerk Lien Record, the Department may initiate proceedings to enforce the order by filing in the Circuit Court for the county where the order is recorded a certified copy of the civil penalty order and a certified copy of the recording made in the County Clerk Lien Record. Subject to any other requirements that may apply to the enforcement proceedings sought by the Department, the court shall then proceed as with judgments issued by the court. The Department may use enforcement proceedings available to the Department in ORS chapter 18.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.994, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, 418.992 - 418.998, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0030, CWP 29-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0121
Denial, Suspension, or Revocation of License and Placing Conditions on a License

(1) The Department may place conditions on a license under this section or any other section of OAR 413-215-0001 through 413-215-1031 including, but not limited to the following:

(a) Placing full or partial restrictions on admission of children;

(b) Temporary suspension;

(c) Limitation of operations subject to an intent to revoke; and

(d) Limitation of operations subject to correction of violations as specified in a plan of correction imposed by the Department.

(2) The Department may suspend, revoke, or place conditions on the child-caring agency's license, certificate, or other authorization in the following circumstances:

(a) The child-caring agency is not in full compliance with the requirements of OAR 413-215-0001(5) or other applicable requirements in OAR 413-215-0001 to 413-215-1031.

(b) The Department finds, after investigation by the Department or law enforcement, that abuses, deficiencies, violations, or failures to comply are founded.

(c) The child-caring agency, or the owner or operator of the child-caring agency including proctor foster homes, interfered with or hindered an investigation of abuse of a child in care, including but not limited to intimidation of witnesses, falsification of records, or denial or limitation of interviews with the child in care who is the subject of the investigation or the witnesses.

(3) The Department may immediately deny, suspend, revoke, or place conditions on the child-caring agency's license in the following circumstances:

(a) The child-caring agency failed to permit an inspection of premises or of the books and records of the child-caring agency.

(b) The child-caring agency failed to make corrections within 45 days from the effective date of the plan of correction under OAR 461-215-0111.

(c) If at any time during or after an investigation that abuses, deficiencies, violations or failures to comply are or threaten a serious danger to any child or to the public, or place a child in care at risk with respect to the child in care's health, safety, or welfare.

(4) The Department will deny issuance or renewal of a license, certificate, or other authorization to a child-caring agency if the child-caring agency is not or will not be in full compliance with all of the standards, procedures, and protocols in OAR 413-215-0001(5) or other applicable requirements in OAR 413-215-0001 to 413-215-1031.

(5) The Department may deny issuance or renewal, suspend, revoke, or place conditions on a license, certificate or other authorization if the Department becomes aware that a child caring agency, or the owner or operator of the child-caring agency, has been found by other state or federal entities to have engaged in financial, civil, or criminal misconduct.

(6) The Department will take immediate steps to suspend or revoke the license of a child-caring agency if any of the following circumstances are found to exist:

(a) There has been the death of a child in care as a result of abuse or neglect on the part of the child-caring agency or any of the child-caring agency's employees or agents;

(b) There has been sexual or physical abuse or neglect of a child in care in the child-caring agency's care or custody that was known to the child-caring agency, and the child-caring agency did not take immediate steps to report the abuse or neglect and to ensure the child in care's safety;

(c) The child-caring agency failed to cooperate fully with any local, state or federal regulatory entity's investigation of the child-caring agency or the child-caring agency's operations or employees; or

(d) The child-caring agency failed to provide financial statements as required under these rules and ORS 418.255.

(7) If a child-caring agency operates under more than one license, the Department may suspend, revoke, or deny the license only as it applies to the facility or facilities out of compliance with applicable statutes or rules.

(8) A child-caring agency may appeal the decision to deny, suspend, or revoke a license in a contested case hearing subject to the provisions of ORS Chapter 183.

(9) To request a contested case hearing, as provided in ORS Chapter 183, the child-caring agency must provide the Department's Licensing Unit a written request for a hearing within 30 days of the date that the Department mailed the notice of denial, suspension, or revocation. If the Department does not receive a request for a contested case hearing within 30 days of the date that the Department mailed the notice of denial, suspension, or revocation, the child-caring agency has waived the right to a hearing, except as provided in OAR 137-003-0528(1).

(10) Except for a child-caring agency that retains a facility with an active license under subsection (6) of this rule, if the Department revokes a license, the child-caring agency may not apply under any name for licensure under this chapter of rules for the three years following the effective date of revocation.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0240, CWP 29-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0126
Temporary, Inactive, and Amended Licenses

(1) Temporary license.

(a) The Department may issue a temporary license when the application by a child-caring agency for a license is approved, and the child-caring agency does not hold a current, valid license. A temporary license is valid for a period not to exceed six months. Use of a temporary license allows the licensee to start providing services authorized by the temporary license. To obtain a temporary license, a child-caring agency must meet all requirements of the rules in Division 413-215 except those that can be met only while providing services.

(b) Once a child-caring agency with a temporary license begins providing services, the licensee must request an inspection by the Department for the purpose of verifying its compliance with the rules in Division 413-215. Upon verification, the Department will issue a license valid for two years beginning from the date of the temporary license, as described in OAR 413-015-0086.

(2) Inactive license.

(a) A child-caring agency is considered to have an inactive license if the child-caring agency discontinues or fails to provide a service for which the child-caring agency is licensed for a period of 180 days.

(b) A child-caring agency no longer providing services for which it is licensed must immediately inform a Department licensing coordinator.

(c) In order to reactivate an inactive license, a child-caring agency must request an inspection by the Department for the purpose of verifying its compliance with all applicable Department rules. The child-caring agency may not resume providing services until the Department has verified in writing that the child-caring agency is in compliance with all applicable Department rules and reinstated the child-caring agency to active status.

(3) Amended license.

(a) The Department may require additional documentation of a licensee if the Department is considering the amendment of a license.

(b) The Department may issue an amended license to a licensee that has an inactive facility or program, but retains another facility or program with an active license.

(c) The Department may issue an amended license upon written request of the licensee to accommodate changes in the factors upon which an existing license is based.

(4) The term of a temporary, inactive, or amended license is not extended by any action described in this rule.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 29-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0131
Exceptions

(1) The Department may waive a requirement of a rule in Division 413-215 upon written request of a child-caring agency. The written request must identify the rule, give the reasons that justify the exception, state the length of time for which the exception is requested, and explain how the needs of children in care and families would be affected if the child-caring agency did not comply with the rule.

(2) The Department may approve a request for an exception upon a determination that the failure of a child-caring agency to comply with the rule does not pose a threat to the health, safety, and welfare of children in care and families. In determining whether to grant an exception, the Department additionally must take into consideration:

(a) Whether the child-caring agency has consistently been in compliance with licensing regulations and has a history or provision of services that meet the best interests of children.

(b) Innovative approaches of the child-caring agency.

(c) The availability of services to children in care and families similar to the services provided by the child-caring agency.

(d) The impact of the rule exception sought.

(e) Whether the Department may waive application of the rule under state statute or federal law.

(3) A child-caring agency granted an exception may, as a condition of obtaining and retaining the exception, be required to provide specific information on its operation under the exception.

(4) A child-caring agency may operate under an exception for a period of time set by the Department, not to exceed the term of its current license.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0250, CWP 29-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0201
Academic Boarding Schools; What Law Applies

(1) These rules, OAR 413-215-0201 to 413-215-0276, regulate a child-caring agency licensed as an academic boarding school. An academic boarding school must also comply with OAR 413-215-0001 to 413-215-0131.

(2) Therapeutic boarding schools (OAR 413-215-0601 to 413-215-0681) and residential care agencies (OAR 413-215-0501 to 413-215-0586) are not subject to OAR 413-215-0201 to 413-215-0276.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0206
Definitions

The following definitions apply to OAR 413-215-0201 to 413-215-0276:

(1) "Academic boarding school" means an organization or a program in an organization that:

(a) Provides educational services and care to children for 24 hours a day; and

(b) Does not hold itself out as serving children with emotional or behavioral problems, providing therapeutic services, or assuring that children receive therapeutic services.

(2) "Approval" means acceptable to the regulatory authority based on conformity with generally recognized standards that protect public health.

(3) "Boarding student" means a student of an academic boarding school who resides on the school campus.

(4) "Care" means services provided to meet the needs of a child, such as food, shelter, clothing, medical care, schooling, protection, and supervision. Care does not include services provided in family foster homes or adoptive homes.

(5) "Child" means an individual under 18 years of age.

(6) "Employee" means an individual holding a paid position with an academic boarding school.

(7) "Facility" means the physical setting, buildings, property, or structures of an academic boarding school.

(8) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance either internally or externally by any person.

(9) "Staff" means employees of the academic boarding school who are responsible for providing direct care to boarding students.

Stat. Auth.: ORS 409.050, 418.005, 418.327
Stats. Implemented: ORS 409.010, 418.005, 418.327
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0211
Educational Services

The educational services of an academic boarding school must comply with all of the following requirements:

(1) The academic boarding school must comply with the minimum requirements for private schools as determined by the Oregon Department of Education.

(2) The academic boarding school must ensure that it has a curriculum that considers the goals of modern education as defined in OAR 581-022-1020 and the requirements of a sound comprehensive curriculum.

(3) Secondary schools must verify that they have academic standards necessary for students to obtain admission to community colleges and institutions of higher education and receive a high school diploma or GED.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0610, CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0216
Physical Plant Requirements

An academic boarding school must meet all of the following requirements:

(1) All buildings owned, maintained, or operated by the academic boarding school to provide services to children must meet all applicable state and local building, electrical, plumbing, and zoning codes.

(2) All areas of buildings where children in care are present must be kept clean and in good repair. Major appliances and heating, ventilation, plumbing, and electrical systems must be functional and in good repair.

(3) Each room used by children in care must have floors, walls, and ceilings that meet the interior finish requirements of the applicable Oregon Structural Specialty Code (see the current version of OAR 837-040-0140) and the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020) and be free of harmful drafts, odors, and excessive noise.

(4) Each room used by children in care must be adequate in size and arrangement for the purpose in which it is used.

(5) A system providing a continuous supply of hot and cold water must be distributed to taps conveniently located throughout each facility.

(6) Water systems serving the property must be installed and maintained in compliance with applicable drinking water regulations (see OAR chapter 333) from the Public Health Division of the Oregon Health Authority.

(7) Heat and ventilation.

(a) Buildings must be ventilated by natural or mechanical means and must be free of excessive heat, condensation, and obnoxious odors.

(b) Room temperature must be maintained within a normal comfort range.

(8) Individual Rooms.

(a) Living area. A separate living room or lounge area must be available for the exclusive use of children in care, employees, and invited guests.

(b) Bedrooms. Bedrooms for children in care may not be exposed to drafts, odors, or noises that interfere with the health or safety of the occupants. Each bedroom must comply with all of the following requirements:

(A) Be separate from the rooms used for dining, living, multi-purpose, laundry, kitchen, or storage.

(B) Be an outside room, with a window of at least the minimum size required by the State Fire Marshal and building codes.

(C) Have a ceiling height of at least 90 inches.

(D) Have a minimum of 60 square feet per bed.

(E) House no more than 25 children in care in one room when a dormitory-style sleeping arrangement is used.

(F) Have permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(G) Have a window covering on each window to ensure privacy.

(H) Contain beds for children in care that meet both of the following requirements:

(i) There must be at least three feet between beds, including trundle beds if used; and

(ii) Bunk beds, if used, must be maintained to ensure safety of the children in care.

(c) Restrooms must be provided and be conveniently located, and must have:

(A) A minimum of one toilet for every eight children in care.

(B) One hand-washing sink with mixing faucets for each toilet. The sink may not be used for the preparation of food or drinks or for dish washing.

(C) Hot and cold running water, soap, and paper towels at each hand washing sink or other hand drying options approved by an environmental health specialist.

(D) One bathtub or shower for every ten children in care.

(E) Arrangements for individual privacy for users.

(F) Permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(G) A window covering on each window to ensure privacy.

(H) Adequate ventilation.

(I) Each self-closing metered faucet, if provided, must provide water flow for at least 15 seconds without the need to reactivate the faucet.

(d) Laundry facilities must be separate from:

(A) Kitchen and dining areas;

(B) Living areas, including bedrooms used by children in care; and

(C) Areas used for the storage of un-refrigerated perishable food.

(e) Storage areas must be provided appropriate to the size of the facility. Separate storage areas must be provided for:

(A) Food, kitchen supplies, and utensils.

(B) Clean linens.

(C) Soiled linens and clothing.

(D) Cleaning compounds and equipment.

(E) Poisons, chemicals, pest control products, insecticides, and other toxic materials, which must be properly labeled, stored in the original container, and kept in a locked storage area.

(F) Outdoor recreational and maintenance equipment.

(f) Food service areas.

(A) Kitchens must have facilities for dish washing, storage, and preparation of food and must be separate from living areas used by children in care.

(B) The walls, floors, and floor coverings of all rooms in which food or drink is prepared or stored or in which utensils are washed or stored must be smooth, washable, and easily cleanable.

(C) All equipment and utensils used for food service, including plastic ware and food-contact surfaces, must be easily cleanable, durable, nontoxic, and non-absorbent and must be maintained in a clean and sanitary condition.

(D) All equipment used for food preparation must be installed and maintained in a manner providing ease of cleaning beneath, around, and behind each unit.

(g) Dining area. A separate dining room or area must be provided for the exclusive use of children in care, employees, and invited guests. The dining area must contain a minimum of 15 square feet per occupant.

(h) Classrooms and school buildings must be adequate in size and arrangement for the programs offered.

(i) Time-out rooms. Rooms used for time out or quiet time must have adequate space, heat, light, and ventilation and must not be capable of locking.

(j) Activity area. A usable recreational activity area must be provided that is:

(A) Protected from motor traffic and other hazards; and

(B) Of a size and availability appropriate to the age and needs of the children in care served by the academic boarding school.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0560, CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0221
Boarding Student Furnishings and Personal Items

An academic boarding school must meet all of the following requirements:

(1) Furniture. Adequate furnishings must be provided for each child in care including:

(a) A bed, including a frame;

(b) A clean, comfortable mattress; and

(c) A private dresser, closet, or similar storage area for personal belongings that is readily accessible to the child in care.

(2) Linens. Linens in good repair must be provided or arranged for each child in care, including:

(a) A waterproof mattress cover or waterproof mattress;

(b) Sheets, pillows, and pillowcase;

(c) Blankets appropriate in number and type for the season and the comfort of the individual child in care; and

(d) Towels and washcloths.

(3) Bedding must be changed when soiled and upon change of the child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0226
New Facility or Remodel

An academic boarding school must meet all of the following requirements:

(1) Building Plans. An academic boarding school must submit to the Department for approval a set of plans and specifications for each facility operated by the academic boarding school and utilized by children in care, at each of the following times:

(a) Prior to construction of a new building;

(b) Prior to construction of an addition to an existing building;

(c) Prior to the remodeling, modification, or conversion of a building; and

(d) In support of an application for initial license to operate an academic boarding school under OAR 413-215-0081.

(2) The required plans must comply with both current Oregon Structural Specialty Codes (see OAR 837-040-0140) and local fire and safety codes.

(3) Plans must be drawn to scale and must specify the estimated date upon which construction, modification, or conversion will be completed.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0570, CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0231
Environmental Health

An academic boarding school must meet all of the following requirements:

(1) The academic boarding school must maintain an environment that ensures safety for staff and children in care.

(2) Environmental Health Specialist approval. Prior to licensure and every two years upon license renewal, the program must be assessed and provide documentation of approval by a registered environmental health specialist (see OAR 338-010-0025 to 338-010-0038) for the following safety areas:

(a) Food service risk assessment.

(b) Drinking water or waste water assessment.

(c) Vector and pest control, including the use of pesticides and other chemical agents.

(d) Hazardous material management, including handling and storage.

(e) Recreation assessments (such as playgrounds, swimming pools, and hot tubs) for injury prevention and hazard mitigation.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0600, CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0236
Food Services

An academic boarding school must meet all of the following requirements with regard to food services:

(1) Nutrition and dietary requirements.

(a) An academic boarding school must arrange meals daily, consistent with normal mealtimes.

(b) Snacks must be available and provided as appropriate to the age and activity levels of children in care.

(c) Menus must be prepared in advance in accordance with USDA guidelines and must provide a sufficient variety of foods served in adequate amounts for each child in care at each meal, adjusted for seasonal changes. Records of menus as served must be maintained in the academic boarding school for at least six months.

(d) Drinking water must be freely available to the children in care served by the academic boarding school.

(2) Food selection, storage, and preparation.

(a) All food and drink provided by the academic boarding school must be stored, prepared, and served in a sanitary manner.

(b) All employees who handle food served to children in care must have a valid food handler's card pursuant to ORS 624.570.

(c) Selection of food. All food products served by an academic boarding school must be obtained from commercial suppliers, except:

(A) Fresh fruits and vegetables and fruits or vegetables frozen by the academic boarding school may be served.

(B) The serving of unpasteurized juice is prohibited.

(d) Requirements related to milk.

(A) Only Grade A pasteurized and fortified milk may be served to children in care.

(B) Milk and fluid milk products must be dispensed from a commercially filled plastic container of not more than one-gallon capacity or from a refrigerated bulk container equipped with a dispensing device approved by the Food and Drug Administration or the Oregon Department of Agriculture.

(e) Children in care may participate in activities in a food-preparation area, other than routine clean up, only while under the supervision of the employees of the academic boarding school.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0580, CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0241
Safety

An academic boarding school must meet all of the following requirements:

(1) Fire safety. Prior to licensure and every two years upon license renewal, the program must be assessed and approved by the State Fire Marshall or designee for the following fire safety areas:

(a) The academic boarding school must provide fire safety equipment which meets the requirements of applicable building codes and the Oregon Fire Code (see OAR 837-040-0010 and 837-040-0020).

(b) The academic boarding school must comply with existing state and local fire safety codes.

(2) Emergency plan.

(a) The academic boarding school must have, for each boarding facility it operates, a written emergency plan that includes:

(A) Instructions for evacuation of children in care and employees in the event of fire, explosion, accident, or other emergency.

(B) Instructions for response in the event of a natural disaster, external safety threat, or other emergency.

(b) Telephone numbers for local police and fire departments and other appropriate emergency numbers must be posted near all telephones.

(c) Operative flashlights sufficient in number must be readily available to the staff in case of emergency.

(3) Evacuation drills.

(a) An unannounced evacuation drill must be held monthly under varying conditions to simulate the unusual conditions that occur in the event of fire. For each drill, the academic boarding school must document the following information and retain it for a minimum of two years:

(A) Identity of the person conducting the drill.

(B) Date and time of the drill.

(C) Notification method used.

(D) Staff members on duty and participating.

(E) Number of children in care and staff evacuated.

(F) Special conditions simulated.

(G) Problems encountered.

(H) Time required to accomplish complete evacuation.

(b) The academic boarding school must ensure that all employees and children in care are aware of the procedures to follow in case of emergencies.

(4) Hazards.

(a) The academic boarding school must protect children in care it serves from guns, drugs, plastic bags, sharps, paint, hazardous materials, bio-hazardous materials, and other potentially harmful materials. An academic boarding school must have a written policy that addresses potentially harmful materials that are in the building accessible to the children in care in the program or on the grounds of the program.

(b) The temperature of hot water used for hand washing, bathing, or showering must be controlled so that it does not exceed 120 degrees

Fahrenheit in all buildings serving children. Direct supervision by staff must be provided for any child in care who does not have the ability to adjust and control water temperature.

(c) Each light fixture must have a protective cover unless it is designed to be used without one.

(5) Transportation. The academic boarding school must ensure the following when providing transportation to the children in care it serves:

(a) Driver requirements.

(A) Each employee transporting a child in care in a motor vehicle must have a current driver license on record with the academic boarding school.

(B) The academic boarding school may use an employee to provide transportation for children in care only if the employee is covered by an insurance policy in full force and effect, and in compliance with the standards set by the academic boarding school.

(C) The academic boarding school must ensure that employees providing transportation are trained in emergency procedures, including behavior management, while in a vehicle.

(D) The academic boarding school must ensure that each person who transports a child in care in a van for 15 or more passengers receives training in the safe operation of that type of vehicle prior to transporting children.

(b) Vehicle requirements.

(A) Each vehicle used to transport a child in care served by the academic boarding school must be covered by an insurance policy in full force and effect.

(B) Each vehicle used to transport a child in care served by the academic boarding school must be maintained in safe operating condition.

(C) Each vehicle used to transport a child in care must meet the vehicle requirements as set by the Department of Education.

(D) Each vehicle used to transport a child in care must be smoke-free.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0550, CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0246
Health Services

(1) An academic boarding school must obtain all private health record information referred to in this rule in a manner that complies with federal and state law.

(2) Medical History. Within 30 days of a child in care starting in an academic boarding school, the academic boarding school must obtain available medical history and other health-related information on the child in care, including:

(a) Significant findings of the most current physical examination;

(b) The child in care's current immunizations, history of surgical procedures and significant health issues or injuries, and past or present communicable diseases;

(c) Any known allergies; and

(d) Physician or qualified medical professional's orders, including those related to medication, if any.

(3) An academic boarding school must have established protocols for accessing routine and urgent medical care for the children in care.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0251
Medication

An academic boarding school must meet all of the following requirements:

(1) Policy and procedures. The academic boarding school must have policies and procedures that cover all prescription and non-prescription medication that address all of the following:

(a) How the medication will be administered.

(b) By whom the medication will be administered.

(2) A prescription, signed by a physician or qualified medical professional, is required before any prescription medication is administered to, or self-administered by a child in care. Medication prescribed for one child in care may not be administered to, or self-administered by another child in care or staff. As used in this rule, "self administration of medication" refers to the act of a child in care placing a medication internally in, or externally on, his or her own body.

(3) Medication storage.

(a) A prescription medication that is unused and any medication that is outdated or recalled may not be maintained in a facility. "Outdated" means any medication whose designated period of potency, as indicated on the label, has expired.

(b) The facility may maintain a stock supply of non-prescription medications.

(c) All prescription and non-prescription medications stored in the facility must be kept in a manner that they are accessible only to staff or the child in care for whom the medication is intended.

(d) A medication requiring refrigeration must be refrigerated and kept in a manner that it is accessible only to staff or the child in care for whom the medication is intended.

(4) Medication disposal. Medication must be disposed of in a manner that ensures that it cannot be retrieved, in accordance with all applicable state and federal law.

(5) A written record of all medications disposed of by the academic boarding school must be maintained and must include all of the following:

(a) A description of the prescribed medication and the amount disposed.

(b) The child in care for whom the medication was prescribed.

(c) The reason for disposal.

(d) The method of disposal.

(e) The name of the adult disposing the medication, and the initials of an adult witness.

(6) Medication Records. A written record must be kept for each child in care listing each medication, both prescription and over-the-counter, that is administered or dispensed by the academic boarding school. The record must include all of the following:

(a) The name of the child in care.

(b) A description of the medication, instructions for use, and the recommended dosage.

(c) Dates and times medication is administered.

(d) A record of missed dosages.

(e) Medication dropped or disposed of.

(f) Method of administration for each medication.

(g) Identification of the person administering the medication.

(h) Any possible adverse reactions to the medication.

(i) Documentation of any medication taken outside the facility to be administered during a home visit or other activity.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0256
Staff Training

In addition to the requirements to provide orientation in OAR 413-215-0061(4), an academic boarding school (defined in 413-215-0206) must meet the all of the following training requirements with respect to its staff (defined in 413-215-0206):

(1) Staff of the academic boarding school must be provided with orientation training prior to or within 30 days of hire.

(2) Staff of the academic boarding school must receive ongoing training at least annually on all of the following:

(a) Mandatory child abuse reporting.

(b) Procedures for handling emergencies.

Stat. Auth.: ORS 409.050, 418.005, 418.327
Stats. Implemented: ORS 409.010, 418.005, 418.327
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0261
Minimum Staffing Requirements

An academic boarding school must meet all of the following requirements:

(1) The academic boarding school must provide adequate supervision and protection for children. The supervision must be adequate for the type of program, location of program, the time of day or night, the age and type of children in care served, physical plant design, location, and ability of the supervisor to respond, electronic backup systems, and other means available to ensure supervision and protection.

(2) Additional staffing requirements for emergency response.

(a) When there is only one employee of the academic boarding school on duty in a facility, there must be additional staff immediately available in the event of an emergency, with a maximum response time of 30 minutes.

(b) One employee who is age 18 or over, has a current certification in cardiopulmonary resuscitation and first aid, and is capable of taking appro-

priate action in an emergency must be on site at all times when one or more children in care are present on the premises of the academic boarding school.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0540, CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0266
Separation of Children

An academic boarding school must meet all of the following requirements:

(1) Combining children and adults. Special care must be taken by an academic boarding school to provide adequate supervision of children in care when adults 18 years of age or older are being served by the academic boarding school. Children in care and adults 18 years or older must be housed in separate bedrooms, except that a child in care and the child in care's parent may be housed in the same room if the parent is the child's caretaker. If a person is 18 years of age or older, and is to share a bedroom with a child in care under the age of 18, the academic boarding school must obtain written approval from the Department licensing coordinator.

(2) Co-ed facilities. Special care must be taken by an academic boarding school to provide adequate supervision when the program serves both males and females concurrently. Children's bedrooms for males must be separated from bedrooms for females.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0271
Consents, Disclosures, and Authorizations

(1) Consents. For each child in care of an academic boarding school, the academic boarding school must ensure that a parent or legal guardian signs a consent that authorizes the academic boarding school to undertake each of the following:

(a) To provide routine and emergency medical care. However, if the parent or legal guardian relies on prayer or spiritual means for healing in accordance with the creed or tenets of a well-recognized religion or denomination, the academic boarding school is not required to use medical, psychological, or rehabilitative procedures, unless the child in care is old enough to consent to these procedures and does so. The academic boarding school must have policies and procedures for this practice, which are reviewed and approved by the child in care's parent or legal guardian.

(b) To provide care to the child in care.

(2) The academic boarding school will make any written policy or procedure pertaining to program services available for review by the child, parent, or legal guardian, upon request.

(3) Authorizations. Authorizations must be pre-approved by the child in care's parent or legal guardian to allow children to participate in potentially hazardous activities, such as but not limited to using motorized yard equipment, swimming, and horseback riding.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0276
Information about Children in Care

Files of Children in Care. For each child in care of an academic boarding school, the academic boarding school must maintain a record that includes all of the following information:

(1) The name, gender, and date of birth of the child in care.

(2) The date of admission to the program.

(3) The name, address, and telephone number of:

(a) The child in care's parents.

(b) The child in care's legal guardian, if different than the parents, and a copy of the document that provides for his or her authority over the child in care.

(4) Incident Reporting. A written description of any injury, accident, or unusual incident involving a child in care must be placed in the individual child in care's record.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 30-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0301
Foster Care Agencies, What Law Applies

These rules, OAR 413-215-0301 to 413-215-0396, regulate a child-caring agency licensed as a foster care agency. A foster care agency must also comply with OAR 413-215-0001 to 413-215-0131.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0400, CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0306
Definitions

(1) "Age-appropriate or developmentally appropriate activities" means:

(a) Activities or items that are generally accepted as suitable for children or young adult of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child or young adult based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and

(b) In the case of a specific child or young adult, activities or items that are suitable for the child or young adult based on the developmental stages attained by the child or young adult with respect to the cognitive, emotional, physical, and behavioral capacities of the child or young adult.

(2) "Approved provider parent" means an individual who a foster care agency, Oregon Youth Authority (OYA), or a governmental agency other than the Department has approved to provide care to children in the home of the individual.

(3) "Certified provider home" means the home of at least one approved provider parent or foster parent that a foster care agency has approved for this individual to provide care to children placed by the foster care agency.

(4) "Criminal history check" means compliance with the Department's criminal records history rules (OAR 407-007-0200 to 407-007-0370). To comply with these rules, the agency must appoint a Contact Person (CP) who is designated to receive and process criminal history and child abuse check forms. Final fitness determinations will be made by the Department.

(5) "Department" means the Department of Human Services, Child Welfare.

(6) "Foster care agency" means a private child-caring agency (defined in OAR 413-215-0006) that offers to place children by taking physical custody of and then placing the children in homes certified by the agency.

(7) "Foster parent" means an individual who operates a home that has been approved by the Department to provide care for an unrelated child or young adult placed in the home by the Department.

(8) "Reasonable and prudent parent standard" means the standard, characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child or young adult while encouraging the emotional and developmental growth of the child or young adult, that a substitute care provider shall use when determining whether to allow a child or young adult in substitute care to participate in extracurricular, enrichment, cultural, and social activities.

Stat. Auth.: ORS 409.050, 418.005, 418.240
Stats. Implemented: ORS 418.205 - 418.325
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0410, CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0311
License Requirements

(1) A foster care agency must be licensed by the Department to certify a home as a proctor foster home.

(2) A foster care agency must be licensed by the Department before the foster care agency accepts physical custody of a child in care for placement in a proctor foster home.

(3) In addition to the requirements in OAR 413-215-0001 to 413-215-0131, to be licensed by the Department, a foster care agency must:

(a) Have a current, written program statement that describes:

(A) The type of provider and foster care provided.

(B) The children in care served.

(C) The services provided to the children in care, their families, their foster families, or their approved provider families.

(D) The geographical area covered.

(b) Have an ongoing recruitment and retention program to ensure an adequate number of suitable proctor foster homes based on the written program statement of the foster care agency.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106

Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0470, CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0313
Personal Qualifications Required for Approved Proctor Foster Parents

(1) To be approved by a foster care agency as an approved proctor foster parent, the applicant must:

(a) Be at least 21 years of age.

(b) Possess the ability to exercise sound judgment and demonstrate responsible, stable, emotionally mature behavior.

(c) Possess the ability to manage the applicant's home and personal life.

(d) Possess the ability to apply the reasonable and prudent parent standard when determining whether to allow a child in care to participate in extracurricular, enrichment, cultural, and social activities.

(e) Maintain conditions in the home that provide safety and well-being for the child in care.

(f) Have supportive relationships with adults and children living in the household and with others in the community.

(g) Have a lifestyle and personal habits free of criminal activity and abuse or misuse of alcohol or other drugs.

(h) Have the physical and mental capacity to care for a child in care. A foster care agency or the Department may, by request, require an applicant to;

(A) Provide copies of medical reports from a health care professional.

(B) Complete an expert evaluation with a report provided to the foster care agency.

(2) A foster care agency may only approve an applicant as an approved proctor foster parent if the applicant meets the requirements of section (1) of this rule.

(3) A foster care agency may only use a proctor foster home if each approved proctor foster parent meets the requirements of section (1) of this rule.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0316
Orientation for Certified Provider Home Applicants

(1) To be approved by a foster care agency to operate a proctor foster home, an applicant must complete orientation training.

(2) In addition to the requirements in OAR 413-215-0061(4) and (5), the orientation training required by section (1) of this rule must, at a minimum, include all of the following:

(a) The policies and procedures of the foster care agency.

(b) The needs and characteristics of children in care needing placement.

(c) Attachment, separation, and loss issues for children in care and families.

(d) The importance of cultural identity to the child in care and ways to foster this identity.

(e) The impact of foster care on the child in care and family.

(f) The rights and responsibilities of the proctor foster parent and the foster care agency.

(g) The resources available to the foster parent or approved proctor foster parent.

(h) Confidentiality.

(i) Rights of families and children in care.

(j) Copies of all of the following documents:

(A) The program statement.

(B) The requirements for proctor foster homes.

(C) The policies of the foster care agency governing proctor foster homes.

(D) The training requirements of the foster care agency for proctor foster homes.

(E) The licensing rules for foster care agencies.

(F) Expectations for working with the foster care agency.

(3) The foster care agency must document in the file of each applicant:

(a) Whether the applicant has received the orientation described in section (2) of this rule;

(b) Whether the foster care agency has provided the notification described in OAR 413-215-0321(4); and

(c) Whether the applicant is approved and a certificate has been issued by the foster care agency to operate a proctor foster home. If a certificate is issued, the foster care agency must document the number and the age range of children in care the home is certified to serve, any specific gender or other restrictions and limitations, and a statement that the foster care agency has determined the proctor foster home meets the standards established in these rules.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0321
Assessment and Approval of Proctor Foster Homes

A foster care agency must comply with all of the following requirements:

(1) Prior to approval of an approved proctor foster parent and prior to the certification of a proctor foster home the foster care agency must complete a proctor foster home assessment for each proctor foster home applicant.

(2) The proctor foster home assessment must be based on an on-site review of the proctor foster home applicant's home, and observations of and interviews with each member of the household, background check information, and any information gathered during the course of the assessment. The foster care agency must require that each applicant submit all of the following:

(a) A completed application. In a two-parent family, the application must be signed by both proctor foster home applicants.

(b) Assurance that the home is the primary residence of the proctor foster home applicant and is the residence where each child in care will reside.

(c) A completed statement of physical and mental health.

(d) If the foster care agency considers it appropriate, a report from a licensed health care or mental health professional concerning any medical, psychological, or substance-abuse problem that might interfere with a proctor foster home applicant's ability to care for a child in care.

(e) A minimum of four references, not more than one of which may be a relative of the proctor foster home applicant.

(3) The foster care agency must complete a written home study that includes all of the following information:

(a) Safety information, including documentation that the home is in full compliance with the safety standards identified in the Safety Assessment Checklist (CF 979).

(b) The names and ages of children in the home and children no longer in the home.

(c) A background check for all members of the household age 18 and over as required by OAR 407-007-0200 to 407-007-0370. A criminal history check for a household member under the age of 18 is required if there is reason to believe that the background check may reveal information that is useful in assessing any risk posed by the household member.

(d) A completed child abuse history background check from every state, where the individual has resided in the last five years and a request for a child abuse history background check from any other country outside of the United States where the individual has resided in the last five years:

(A) For all members of the household age 18 and over; and

(B) For a household member under the age of 18 if there is reason to believe that the child abuse history check may reveal information that is useful in assessing any risk posed by the household member.

(e) The proctor foster home applicant's placement preferences.

(f) The proctor foster home applicant's motivation for providing foster care.

(g) The proctor foster home applicant's life experiences and challenges.

(h) The proctor foster home applicant's relevant health history. Each proctor foster home applicant in a proctor foster home must assure that a child in care will not be exposed to any type of second hand smoke in the home or in family vehicles, and that no member of the household provides any form of tobacco products to a child in care.

(i) The proctor foster home applicant's education and training.

(j) The proctor foster home applicant's employment and finances.

(k) The proctor foster home applicant's need for support services and description of current support systems.

(l) The proctor foster home applicant's marital history, including previous marriages, divorces, and long-term relationships.

(m) The proctor foster home applicant's parenting skills and values.

(n) The proctor foster home applicant's lifestyle.

(o) The proctor foster home applicant's religion or spiritual beliefs.

(p) Cultural background and experiences with diverse cultural groups.

(q) An assessment of current and previous licenses, certifications, and applications for relative care, adult or child foster care, day care, adoption, and other types of services for vulnerable individuals, including adult care giving. Information must include any denials, suspensions, revocations, or terminations.

(r) An assessment of the areas in which training is needed and the plan of the foster care agency for providing needed training, including time frames.

(s) The proctor foster home applicant's home and community.

(t) Summary assessment and recommendations including the characteristics and maximum number of children in care who may be placed in the proctor foster home.

(4) A process for notifying proctor foster home applicants. The foster care agency must notify each proctor foster home applicant in writing of the acceptance or denial of the application for approval as a proctor foster home and certification as a proctor foster home. If the foster care agency denies an application based on information provided by the Department to the foster care agency concerning an ongoing abuse or neglect investigation involving the applicant or findings of substantiated allegations of abuse or neglect by the applicant, the foster care agency must disclose to the proctor foster home applicant the reason for the denial.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0326
Training for Parents in Proctor Foster Care

(1) The foster care agency must have and follow a written training plan that:

(a) Provides each proctor foster home parent in a proctor foster home a minimum of 15 hours of training before the foster care agency places a child in care in the home.

(b) Provides each proctor foster home parent in a proctor foster home a minimum of 15 hours of training annually prior to the issuance of the annual approval required by OAR 413-215-0331.

(c) The training plan must include all of the following topics:

(A) Characteristics and needs of children in care who may be placed with the proctor foster home.

(B) Ways to effectively parent children in care who are placed by the foster care agency, including application of the reasonable and prudent parent standard.

(C) Positive behavior management, non-punitive discipline.

(D) The importance of the family of the child in care and working with the family of the child in care.

(E) The importance of age-appropriate or developmentally appropriate extracurricular, enrichment, cultural, and social activities.

(F) Preparation of the child in care for independence based on the age, stage of development, and needs of the child in care.

(G) Legal responsibility to report suspected child abuse.

(2) The foster care agency must document in proctor foster home records the training received by each proctor foster home parent.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0440, CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0331
Annual Review and Approval

A foster care agency must comply with all of the following requirements:

(1) The foster care agency must evaluate every proctor foster home at least once every twelve months to ensure that the home continues to meet the standards.

(2) The annual review must include all of the following:

(a) The foster care agency must update the written home study required by OAR 413-215-0321(3).

(b) A background check for all members of the household age 18 and over must be completed as required by OAR 407-007-0200 to 407-007-0370. A background check for a household member under the age of 18 is required if there is reason to believe that a background check may reveal information that is useful in assessing any risk posed by the household member.

(c) A completed state of Oregon child abuse history background check must be completed:

(A) For all members of the household age 18 and over; and

(B) For a household member under the age of 18 if there is reason to believe that the child abuse history check may reveal information that is useful in assessing any risk posed by the household member.

(d) If an adult member of the household has lived outside the state of Oregon in the previous five years, and an out-of-state child abuse history background check has not been completed, a child abuse history background check must be requested from each state or foreign country where the individual resided in the last five years.

(e) Documentation that the home remains in full compliance with the safety standards identified in the Safety Assessment Checklist (CF 979).

(f) A recommendation to approve or deny the re-issuance of the certificate of approval of the proctor foster home. If the agency denies renewal based on information provided by the Department to the agency concerning an ongoing abuse or neglect investigation involving the applicant or findings of substantiated allegations of abuse or neglect by the proctor foster home applicant, the agency must disclose to the proctor foster home applicant the reason for the denial.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0480, CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0336
Complaints about Proctor Foster Homes

(1) Employees of the foster care agency are covered by the requirements to report suspected child abuse in ORS 419B.010 and, in addition to any other requirements of law, must refer a complaint of suspected child abuse to the Department for investigation.

(2) If the foster care agency receives information alleging a proctor foster home is not in compliance with the certification requirements of the foster care agency, including, but not limited to the rules in OAR 413-215-0001 to 413-215-0131 and OAR 413-215-0301 to 413-215-0396, the foster care agency must immediately initiate an on-site assessment of the home and report the complaint to the Department.

(a) As part of the assessment, the foster care agency must prepare a detailed written report that includes all of the following information:

(A) The name of the foster care agency employee who received the complaint, date the complaint was received, name of complainant, and the allegations.

(B) Dates and places of contacts, the names of persons interviewed or observed, and the names of the interviewers.

(C) Findings, summary, and conclusions regarding compliance or noncompliance and recommendations regarding corrective action.

(b) The foster care agency must complete the assessment within 30 days following the receipt of the complaint and must provide a copy of the written assessment to a Department licensing coordinator.

(c) The foster care agency must provide the proctor foster parent with a copy of the report of the assessment once it is complete, and must inform the proctor foster parent in writing that he or she has a right to have his or her response included in an attachment to the report.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0341
Closures of Proctor Foster Homes

If a foster care agency decertifies a proctor foster home, the foster care agency must provide the proctor foster home parent or parents a written notice of the specific reasons for the action, must retain a copy of the notification in the record of the proctor foster home, and must notify the Department.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0346
Modifications to the Certification of a Certified Provider Home

A foster care agency (defined in OAR 413-215-0306) must document all of the following in the record of each certified provider home (defined in OAR 413-215-0306):

(1) Change of address of a parent.

(2) Change in name of a parent.

(3) Change in household composition.

(4) Any exceptions to or suspensions of the certification by the foster care agency of a certified provider home.

(5) Inactive referral status.

Stat. Auth.: ORS 409.050, 418.005, 418.240
Stats. Implemented: ORS 418.205 - 418.325
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0349
Notifications Required of Proctor Foster Home Parents

A foster care agency must require proctor foster home parents in a proctor foster home to notify the foster care agency of each of the following:

(1) Any physical or structural changes in the proctor foster home in which they live.

(2) Any arrests or court convictions of any member of the household. A parent of the proctor foster home must notify the foster care agency within one working day of learning about the arrest or conviction.

(3) Any allegation of child abuse or neglect perpetrated by any member of the household or any individual who regularly visits the proctor foster home. A proctor foster home parent must notify the foster care agency on the day he or she learns of the allegation.

(4) The suspension of a driver's license of any adult on the Certificate of Approval or any member of the household.

(5) Any change in the physical or mental health of a member of the household that reasonably could affect the ability of the proctor foster home to meet the safety needs of the child in care.

(6) Any time a member of the household applies to become an in-home child care provider, an adult foster care, or in-home adult day care provider.

(7) Any other circumstance that could reasonably affect the safety or well-being of a child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0351
Records of Certified Provider Homes

(1) A foster care agency must safely and consistently maintain a record for each proctor foster home it approves. Such records must be separate from records the foster care agency maintains on the children in care and families it serves.

(2) The record for each proctor foster home must contain all of the following:

(a) All documents pertaining to approval of the proctor foster home.

(b) All documents pertaining to formal complaints about the proctor foster home.

(c) The contract between the foster care agency and the parents in the proctor foster home.

(d) A list of all children in care placed in the proctor foster home that includes identifying and placement information.

(e) Documentation that the foster care agency conducted a minimum of one home visit every 180 days to assure compliance with certification standards.

(3) A foster care agency must document all of the following in the record of each proctor foster home:

(a) Change of address of a proctor foster home parent.

(b) Change in name of a proctor foster home parent.

(c) Change in household composition.

(d) Any exceptions to or suspensions of the certification by the foster care agency of a proctor foster home.

(4) Inactive referral status.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0450, CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0356
Placement of a Child by a Foster Care Agency

(1) A foster care agency may place a child in care in a proctor foster home.

(2) The placement of a child in care in a proctor foster home must be consistent with the recommendations for the use of the proctor foster home as identified in the current home assessment.

(3) The foster care agency may not issue a certification for a proctor foster home that allows the proctor foster home to exceed any of the following subsections:

(a) A total of four children to one approved proctor foster parent living in the home;

(b) A total of seven children to two approved proctor foster parents living in the home; or

(c) A total of two children under the age of three.

(4) The foster care agency must base each placement on an assessment of the individual needs of the child in care and an assessment of the ability of the proctor foster home to meet those needs. The foster care agency must document the basis for the selection in the file of the proctor foster home.

(5) Sleeping Arrangements.

(a) Children in care must be housed in separate bedrooms, except that a child in care who is the parent of a minor child may be housed in the same room if the parent is the caretaker of the child. If a child in care is 18 years of age or older and is to share a bedroom with a child in care less than 18 years of age, written approval must be obtained from the Department licensing coordinator.

(b) The foster care agency must consider the age, gender, special needs, behavior, and history of abuse or neglect of the child in care in determining appropriate sleeping arrangements.

(c) Unrelated children in care may not share a bed.

(6) The foster care agency must provide to the proctor foster home a copy of the signed contract and maintain a copy in the proctor foster home file.

(7) At the time of placement of each child in care in a proctor foster home, the foster care agency must provide the proctor foster home parents with all of the following information and authorizations:

(a) The name and date of birth of the child in care, and the reason for placement.

(b) The name of the assigned worker and a telephone number to contact the foster care agency.

(c) Information about the health, behavioral characteristics, and needs of the child in care.

(d) Authorization and clear written instructions for obtaining medical, dental, and other professional care, and authorization for emergency medical care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0361
Documentation Required When a Foster Care Agency Changes a Placement

Within seven working days after a child in care is moved out of a proctor foster home and placed in a different proctor foster home, a foster care agency must record all of the following information in the case record:

(1) The reason for the new proctor foster home; and

(2) The name and address of the new proctor foster home.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0366
Respite Care

A foster care agency must comply with all of the following requirements:

(1) The foster care agency must have a respite care policy for each proctor foster home that addresses the need to provide children in care with safe and adequate care when the proctor foster home parents are not present.

(2) The respite care policy of the foster care agency must include the following:

(a) The foster care agency is responsible for identifying and selecting safe and responsible alternate caregivers for a child in care placed in a proctor foster home:

(A) Each alternate caregiver must be at least 21 years of age;

(B) The foster care agency must assure completion of background checks (pursuant to OAR 407-007-0200 to 407-007-0370); and

(C) Prior to determining that the alternate caregiver is safe and appropriate to provide relief or respite care, the foster care agency must analyze information relevant to paragraphs (A) and (B) of this subsection.

(b) The proctor foster home must receive the approval of the foster care agency prior to using a relief or respite caregiver.

(c) The proctor foster home is responsible for notifying the foster care agency in advance when the parents plan to provide relief or respite care for another proctor foster home and the number of children in care will exceed the maximum number of children in care authorized.

(d) There must be a respite care plan relating to the age, developmental ability, and special needs of each child in care placed in the proctor foster home.

(e) There must be plans for respite care in the event of an emergency that makes a proctor foster home unavailable.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0371
Training of Foster Care Agency Staff

In addition to the orientation requirements in OAR 413-215-0061(4) and (5), a foster care agency must meet all of the following training requirements with respect to its employees:

(1) Staff of the foster care agency must be provided with orientation training prior to or within 30 days of hire. The orientation must include training on all of the following:

(a) Discipline and behavior management protocols including de-escalation skills training, crisis prevention skills, positive behavior management, and disciplinary techniques that are non-punitive in nature and are focused on helping children build positive personal relationships and self-control.

(b) If restraint and seclusion are utilized by the program, the approved techniques and monitoring procedures. The policy and training provided by the foster care agency must be clear that restraint or seclusion is used as an intervention of last resort.

(2) In addition to annual mandatory child abuse training, staff of the foster care agency must receive ongoing training at least annually on all of the following:

(a) Procedures for handling environmental emergencies.

(b) Universal precautions (infection control guidelines designed to protect workers from exposure to diseases spread by blood and certain body fluids) and hygiene.

(c) Discipline and behavior management.

(3) Staff of the foster care agency must receive training in cardiopulmonary resuscitation and first aid sufficient to retain a current certification.

(4) Staff of the foster care agency must receive training related to the reasonable and prudent parent standard and age-appropriate or developmentally appropriate activities.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0430, CWP 31-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0376
Health Services

A foster care agency must comply with all of the following requirements:

(1) The foster care agency must obtain all private health record information referred to in this rule in a manner that complies with federal and state law.

(2) Medical History. Within 30 days after the foster care agency assumes physical custody of a child in care, the foster care agency must obtain available medical history and other health-related information on the child in care, including:

(a) Significant findings of the most current physical examination;

(b) The child in care's current immunizations, history of surgical procedures and significant injuries, and past or present communicable diseases, to the extent such information is available under ORS 192.518 to 192.526;

(c) Any known allergies;

(d) Dental, vision, hearing, and behavioral health;

(e) Documentation that the child in care has received age-appropriate instruction regarding pregnancy prevention, nutrition, prevention of HIV and AIDS, and general information about the prevention and treatment of sexually transmitted diseases; and

(f) Physician's orders, including those related to medications, if any.

(3) Health services. The foster care agency must provide or arrange for the following health services, as applicable:

(a) Information on maintaining reproductive health and birth control.

(b) Prenatal care.

(c) Well-baby care.

(d) Fetal alcohol syndrome.

(e) Accessing child and infant health insurance programs.

(f) Screening for breast and other common cancers.

(g) Provide all necessary feminine hygiene products.

(h) Access to birth control, vaccinations, and information about preventing sexually transmitted diseases.

(4) Medical examinations. The foster care agency must safeguard the health of each child in care it serves by providing for a medical examination by a physician or qualified health professional at the following intervals:

(a) Three examinations during the first year of the child in care's life.

(b) One examination at the age of two.

(c) One examination at the age of four.

(d) One examination at the age of six.

(e) One examination at the age of nine.

(f) One examination at the age of fourteen.

(5) The foster care agency must have established protocols for accessing routine and urgent care for children in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0381
Medication

A foster care agency must comply with all of the following requirements:

(1) Policy and procedures. The foster care agency must have policies and procedures that cover prescriptions, herbal remedies, and all non-prescription medications that address all of the following:

(a) How the medication will be administered.

(b) By whom the medication will be administered.

(c) How the staff of the foster care agency and the proctor foster home parents who administer medication will be trained.

(d) How the administration of medication will be documented.

(e) How the administration of medication will be monitored.

(f) How unused medication will be disposed of.

(g) The process that ensures that each child in care's prescription and non-prescription medications are reviewed, unless the medications are all provided through a single pharmacy. As used in this rule, "non prescription medication" means any medication that does not require a written prescription for purchase or dispensing.

(2) A prescription, signed by a physician or qualified health professional, is required before any prescription medication is administered to, or self-administered by a child in care. Medications prescribed for one child in care may not be administered to, or self-administered by another child in care, proctor foster home, or staff. As used in this rule "self administration of medication" refers to the act of a resident placing a medication internally in, or externally on, his or her own body.

(3) A written order, signed by a physician or qualified health professional, is required for any medical treatment, special diet, physical therapy, aid to physical functioning, or limitation of activity.

(4) Before a foster care agency permits a child in care to self-administer prescription medication, self-administration must be recommended by the foster care agency, approved in writing by a physician, and closely monitored by the proctor foster home parent or the staff of the foster care agency.

(5) Medication storage.

(a) Prescription medications that are unused and medication that is outdated or recalled may not be maintained in a proctor foster home. "Outdated" means any medication whose designated period of potency, as indicated on the label, has expired.

(b) The proctor foster home may maintain a stock supply of non-prescription medications.

(c) All prescription and non-prescription medications stored in the proctor foster home must be kept in a manner that they are inaccessible to children in care.

(d) Medications requiring refrigeration must be refrigerated and secured.

(e) Medications must be maintained and stored in its original container, including the prescription label.

(6) Medication disposal. Medications must be disposed of in a manner that ensures that they cannot be retrieved, in accordance with all applicable state and federal law.

(7) A written record of all medication disposals must be maintained and must include all of the following:

(a) A description of the prescribed medication and the amount disposed.

(b) The child in care for whom the medication was prescribed.

(c) The reason for disposal.

(d) The method of disposal.

(e) The name of the adult disposing the medication, and the initials of an adult witness.

(8) Medication records. A written record must be kept for each child in care listing all medications, both prescription and over-the-counter, that is administered. The record must include all of the following:

(a) The name of the child in care.

(b) A description of the medication, instructions for use, and the recommended dosage.

(c) Dates and times medication is administered.

(d) A record of missed dosages.

(e) Medication dropped or disposed of.

(f) Method of administration for each medication.

(g) Identification of person administering the medication.

(h) Any possible adverse reactions to the medication.

(i) Documentation of any medication taken out of the proctor foster home by a child in care during a home visit or other activity.

(9) Where applicable, the foster care agency must maintain documentation of the continuing evaluation of the ability of the child in care to self-administer a medication.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0386
Referral and Initial Evaluation of Children

A foster care agency must comply with all of the following requirements:

(1) Referral. The foster care agency must have a policy that addresses the process by which children in care are referred to the foster care agency. The policy must include all of the following:

(a) From whom referrals are accepted.

(b) On what basis children in care are accepted by the foster care agency.

(c) How information necessary to provide for the safety and care of children in care will be provided to proctor foster home parents, and staff of the foster care agency.

(2) Initial evaluation of a child. The foster care agency must evaluate each child in care referred to the foster care agency for placement. In conducting the evaluation, the foster care agency must:

(a) Request and review all available reports of the child in care's past and present behavior, educational status, and physical and mental health.

(b) Make a preliminary determination whether the prospective child in care has disorders, disabilities, or deficits due to mental, emotional, behavioral, or physical problems for which care, supervision, training, rehabilitation, or treatment is needed to reduce a problem, maintain present level of functioning, or clarify the ongoing placement or service needs of the child in care.

(3) The foster care agency must be prepared to provide to a parent or legal guardian of a referred child suggestions for obtaining resources in the event the child is not accepted by the foster care agency for placement.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0391
Consents, Disclosures, and Authorizations

(1) Consents. For each child in care taken into the physical custody of a foster care agency, the foster care agency must ensure that a parent or legal guardian signs a consent that authorizes under what circumstances the foster care agency may undertake each of the following, as applicable:

(a) To provide routine and emergency medical care. If a foster care agency relies on prayer or spiritual means for healing in accordance with the creed or tenets of a well-recognized religion or denomination, the foster care agency may not require medical, psychological, or rehabilitative procedures. The foster care agency must have policies and procedures for this practice, which are reviewed and approved by the parent or legal guardian of the child in care.

(b) To use the discipline and behavior management systems of the foster care agency, utilized by the foster care agency.

(c) To use restraint or seclusion in the management of the child in care. The consent must specify the reasons such interventions are used by the foster care agency and how the employees of the foster care agency and proctor foster home parents are trained and supervised in the use of restraint or seclusion.

(d) To restrict the child in care's contact with persons outside the foster care agency and the proctor foster home, including visits, telephone communication, electronic mail, and postal mail, except that access to a child in care must be allowed as provided in ORS 418.305 and OAR 413-215-0091(11).

(e) To impose a dress code.

(f) To apply the reasonable and prudent parent standard to determine whether the child in care is allowed to participate in age-appropriate or developmentally appropriate activities, including extracurricular, enrichment, cultural, and social activities.

(2) Disclosures. At admission, the foster care agency must ensure that each parent or legal guardian of the child in care receives and acknowledges in writing the receipt of each of the following policies and requirements of the foster care agency:

(a) Mandatory child abuse reporting requirements.

(b) Information regarding any personal or room searches and protocols for confiscation of contraband items, including the notification of law enforcement if illegal contraband is discovered. This information will include the procedures and rationales of the foster care agency for any program-initiated room or body search.

(c) A statement concerning the rights of children in care and parents or legal guardians served by the foster care agency as provided in OAR 413-215-0046. The statement must be written in a manner that is easy to understand, and the foster care agency must ensure that the child in care and the parent or legal guardian understand the statement and the requirement that the agency afford the children in care each of these rights.

(d) The grievance policies and procedures of the foster care agency.

(e) The foster care agency will make any written policy or procedure pertaining to program services available for review by the child in care, parent, or legal guardian, upon request.

(3) Authorizations.

(a) Authorization to disclose information from other service providers must be filled out prior to signatures being requested and be specific to one other provider. Information may only be requested on a need-to-know basis.

(b) All child-specific visitors of the child in care must be approved or authorized by the parent or legal guardian, except court appointed special advocates (CASA) and attorneys appointed to represent the child.

(c) Visitation resources must be pre-approved by the parent or legal guardian of the child in care and the identity of these resources verified by the foster care agency.

(d) Activity-specific authorizations must be pre-approved by the parent or legal guardian of the child in care to allow participation in potentially hazardous activities, such as using motorized yard equipment, swimming, and horseback riding.

(e) All other required authorizations must be pre-approved by the parent or legal guardian of the child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: CWP 31-2008, f. & cert. ef. 10-17-08; ; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0396
Information About Children in Care Placed in Physical Custody of the Foster Care Agency

A foster care agency must comply with all of the following requirements:

(1) Case files for children in care. For each child in care the foster care agency accepts for placement, the foster care agency must maintain an individual record that includes a summary sheet containing all of the following information:

(a) The name, gender, date of birth, religious preference, and previous address of the child in care.

(b) The name and location of the child in care's previous school.

(c) The date of admission to the program.

(d) The status of the child in care's legal custody, including the name of each person responsible for consents and authorizations.

(e) The name, address, and telephone number of:

(A) The parents of the child in care.

(B) The legal guardian of the child in care, if different than parents, and his or her legal relationship to child.

(C) Other family members or other persons identified by the family as significant to the child in care.

(D) Other professionals to be involved in service planning, if applicable.

(2) Service planning.

(a) All documentation, including but not limited to service plans, daily notes, assessments, progress reports, medication records, and incident reports, must be written in terms that are easily understood by all persons involved in service planning.

(b) Intake documentation. A foster care agency must complete a written intake document containing screening information on the date the foster care agency accepts a child in care except in the case of an emergency placement, when the intake document must be completed within 48 hours of admission.

(c) Each child in care must be served according to an individual written service plan developed by staff of the foster care agency and including, whenever possible, the child in care, the child in care's family, and other professionals involved with the child in care or family. This document must outline goals for services and care coordination.

(d) Assessment. A comprehensive assessment must be completed within the first 30 days of placement. This assessment must include relevant historical information, current behavioral observations, any identified needs for services, and a description of how the foster care agency will provide or coordinate services.

(e) Service plan and review.

(A) Within 60 days of placement, a formal service plan must be developed by staff of the foster care agency in conjunction with the child in care and his or her parents or legal guardians, and any other persons who are actively involved with the family, as appropriate.

(B) The service plan must reflect how the foster care agency will address the child in care's issues, describe the anticipated outcomes of the placement, and be reviewed and approved by the child in care and the legal guardian or parent, unless contraindicated.

(C) The service plan must be reviewed by the foster care agency at least quarterly.

(D) Service plans must be revised at any time additional information becomes available indicating that other services should be provided.

(3) Case management.

(a) The foster care agency must document services provided, as necessary, to track and monitor progress toward the achievement of service plan goals.

(b) Discharge. The foster care agency must identify how a child in care's progress will be evaluated, and how the determination is made of readiness for discharge or unsuitability for continued stay.

(c) Discharge planning. Discharge planning for a child in care must be a participatory decision-making process between the child in care, staff of the foster care agency, the parent or legal guardian, and significant others. As used in this rule, "significant others" means relatives, friends, or interested members of the community who are approved by the parent or legal guardian.

(d) Discharge instructions. The foster care agency must provide the child in care and the child in care's guardian with discharge instructions on or before the discharge date, including current medications, name of the doctor who prescribed each medication, any outstanding medical or other appointments, and other follow-up instructions as needed.

(e) Follow-up services. The foster care agency must identify any transitional or aftercare services or service coordination that will be offered by the program.

(f) Incident reporting. A written description of any injury, accident, or unusual incident involving a child in care must be placed in the individual child in care's record.

(4) Financial records. A foster care agency must keep a separate written record for each child in care itemizing all money received or disbursed on behalf of the child in care. The record must include all of the following:

(a) The date of each receipt and disbursement and the amount of each.

(b) The source of income.

(c) The purpose of each disbursement.

(d) The signature of the person making each entry.

(e) The signature of the child in care for each entry.

(5) Personal possessions records. An individual written inventory must be maintained for each child in care of all personal possessions belonging to the child in care. The record must be updated as needed.

(6) The foster care agency will ensure, in policy, that:

(a) Disallowable items are either stored, or returned to the parent or legal guardian; and

(b) All money and personal belongings are returned to the child in care, child in care's parent or legal guardian at the time of discharge, or an account provided of any missing items.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0460, CWP 31-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0401
Adoption Agencies, What Law Applies

These rules, OAR 413-215-0401 to 413-215-0481, regulate a child-caring agency licensed as an adoption agency. An adoption agency must also comply with OAR 413-215-0001 to 413-215-0131.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-94, cert. ef. 12-29-95; Renumbered from 413-220-0090, CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0406
Definitions

As used in OAR 413-215-0401 to 413-215-0481:

(1) "Adoption agency" means an organization providing any of the following services:

(a) Identifying a child for adoption and arranging an adoption.

(b) Securing the necessary consent to relinquishment of parental rights and to adoption.

(c) Performing a background study on a child or a home study on a prospective adoptive parent and reporting on such a study.

(d) Making determinations of the best interests of a child and the appropriateness of adoptive placement for the child.

(e) Monitoring a case after *placement* until final adoption.

(f) When necessary because of *disruption* before final adoption, assuming custody and providing childcare or other social services for the child pending an alternative placement.

(2) "Birth parent" means each person who holds a legally recognized parental relationship to the child but does not include the adoptive parents in the adoption arranged by the adoption agency.

(3) "Criminal history check" means compliance with the Department's criminal records history rules (OAR 407-007-0200 to 407-007-0370). To comply with these rules, the agency must appoint a Contact Person (CP) who is designated to receive and process criminal history and child abuse check forms. Final fitness determinations will be made by the Department.

(4) "Disruption" means the interruption of an adoptive placement prior to the finalization of the adoption in a court of law.

(5) "Intercountry adoption" means an adoption in which a child who is a resident and citizen of one country is adopted by a citizen of another country.

(6) "Placement" of a child occurs when the child is placed in the physical or legal custody of prospective adoptive parents.

(7) "Re-adoption" means a process in which a child whose adoption was completed in another country is re-adopted in this country.

(8) "Special needs" mean a trait or disability of a child that requires special care or attention of the child or that historically has made placement of a child with similar characteristics or disability difficult.

Stat. Auth.: ORS 409.050, 418.005, 418.240
Stats. Implemented: ORS 418.205 - 418.310
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0411
Information and Reporting Requirements of an Adoption Agency

(1) Public information.

(a) An adoption agency must provide to each person making an inquiry about adoption a written program statement that describes the services of the adoption agency and includes all of the following information:

(A) A description of the children normally placed by the adoption agency.

(B) Eligibility requirements for adoptive families.

(C) Timelines for intake screening and for being placed on a waiting list.

(D) A clear delineation of fees, charges, contributions, or donations required to obtain adoption services.

(E) The services provided during the adoption process.

(F) The geographical area covered by the adoption agency.

(b) The written and electronic materials of an adoption agency describing its adoption program must be accurate, must be reviewed regularly for accuracy, and must include the date the material was last updated.

(2) Cost disclosures. An adoption agency must provide the following information regarding the costs of an adoption:

(a) The adoption agency must provide all of the following information to all prospective adoptive parents:

(A) A written schedule of estimated fees and expenses.

(B) An explanation of the conditions under which estimated fees or expenses may be charged, waived, reduced, increased, or refunded.

(C) When, how, and to whom the estimated fees and expenses must be paid.

(b) Before providing an adoption service to a prospective adoptive parent, the adoption agency must itemize and disclose in writing to the parent the estimated fees and expenses the parent will be charged related to each of the following:

(A) A home study.

(B) The adoption agency fees in the United States.

(C) Other–country program expenses, if applicable.

(D) Translation and document expenses, if applicable.

(E) Travel and accommodation expenses, if applicable.

(F) Contributions.

(G) Post-placement and post-adoption reports.

(H) Likely charges of the U.S. Citizenship and Immigration Services (USCIS).

(I) Legal finalization or re-adoption expenses, if applicable

(c) The adoption agency must specify in its written adoption contract when and how funds advanced to cover fees or expenses will be refunded if adoption services are not provided.

(d) When the delivery of adoption services is completed, the adoption agency must provide the prospective adoptive parents, within 30 days following the completion of services, a detailed written accounting of the total fees and expenditures for which the adoptive parents will be charged by the adoption agency.

(3) Data collection requirements. An adoption agency must maintain in a standard and accessible format all of the following information and make it available on request:

(a) The number of adoption placements it completes each year for the prior three calendar years, and the number and percentage of those placements that remain intact, are disrupted, and have been dissolved as of the time the information is provided.

(b) The number of parents who apply with the adoption agency to adopt a child in care each year.

(c) The number of waiting children available for adoption that the adoption agency is attempting to place.

(4) Mandatory reporting of disruption and dissolution. The adoption agency must submit to the Department on a prescribed form a written report within 14 days after a disruption or dissolution is reported to the adoption agency if the adoption agency was involved in the study of the family, the placement of the child in care, or the supervision of the adoptive placement. As used in this rule, "dissolution" means the termination of an adoptive placement after finalization.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0416
Adoption Agency Staff

In addition to meeting the requirements in OAR 413-215-0021(3):

(1) Required staff. An adoption agency must have an executive director and a social services supervisor. If one person fills both positions, that person must meet the qualifications of both the executive director and the social services supervisor listed in subsections (2)(a) and (b) of this rule.

(2) Qualifications.

(a) The executive director must possess all of the following qualifications:

(A) Management skills and abilities.

(B) A bachelor's degree from an accredited program.

(C) Two years of full-time experience in child social services.

(b) The social services supervisor must possess all of the following qualifications:

(A) A master's or doctorate degree from an accredited program in social work, psychology, guidance and counseling, or a similar subject area.

(B) Two years of experience in family and children's services, one year of which must include providing adoption services.

(C) If the agency provides intercountry adoption services, the supervisor must have experience in intercountry adoptions.

(c) An incumbent executive director or social services supervisor employed by the adoption agency prior to October 17, 2008 — of an adoption agency already licensed by the Department — who does not meet the qualifications listed is subsections (a) and (b) of this section is deemed to meet those requirements if he or she had been in the position for at least three years, had significant skills and experience with the adoption process, and has access to consultation with persons having the qualifications listed in subsections (a) and (b) of this section, as applicable.

(d) Social services staff, who are non-supervisory employees providing adoption-related social services requiring the application of clinical skills and judgment, must possess:

(A) A master's degree from an accredited program of social work education or another human service field;

(B) A bachelor's degree from an accredited program of social work education; or

(C) A combination of a bachelor's degree in another human service field and experience in family and children's services or adoption.

(3) Supervision. All non-supervisory social services staff described in subsection (2)(d) of this rule must be supervised by an employee of the adoption agency who meets the requirements for social services supervisor set forth in subsection (2)(b) or (2)(c) of this rule.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-94, cert. ef. 12-29-95; Renumbered from 413-220-0040, CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0421
Staff Training Requirements for Adoption Agencies

An adoption agency must meet all of the following requirements related to its staff:

(1) The adoption agency must have a comprehensive plan for providing basic training to newly hired social services employees on the issues that arise with adoptive placement.

(2) The adoption agency must ensure that all social services staff and contracted social services providers obtain a minimum of 10 hours of training annually on issues related to adoption.

(3) The adoption agency must ensure that all social services staff and all persons who provide adoption services complete training in all of the following areas:

(a) The potential short- and long-term effects of prenatal exposure to alcohol, drugs, and poor nutrition.

(b) The potential effects of separation and loss.

(c) The process of developing emotional ties to an adoptive family.

(d) Normal child and adolescent development.

(e) The potential effects of physical abuse, sexual abuse, neglect, and institutionalization on the development of the child in care.

(f) The potential issues of race, culture, and identity; issues of acculturation and assimilation; and, if applicable, the effects of having been adopted internationally.

(g) The emotional adjustment of adopted children and their families.

(h) Open adoption.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0426
Policies and Procedures for Adoption Agencies

An adoption agency must have and follow written policies and procedures for the adoption services it provides including, at a minimum all of the following:

(1) Policies and procedures prescribing safeguards relating to the needs, rights, and responsibilities of the following:

(a) A birth parent who is considering the release of a child in care for adoption;

(b) A child in care who becomes available for adoption; and

(c) A family who adopts a child in care.

(2) Policies and procedures designed to ensure compliance by the adoption agency all applicable federal and state laws, including but not limited to:

(a) The Indian Child Welfare Act of 1978, Pub. L. No. 95-608, 92 Stat. 3069 (1978) (ICWA)(see OAR 413-070-0100 to 413-070-0260);

(b) The Interstate Compact for Placement of Children (ICPC) (see ORS 417.200);

(c) Section 1808 of the Small Business Job Protection Act of 1996, Pub. L. No. 104-188, 110 Stat. 1903 (1996), amending 42 U.S.C. § 671;

(d) The Howard M. Metzenbaum Multiethnic Placement Act of 1994, Pub. L. No. 103-382, 108 Stat. 4056 (1994);

(e) The Intercountry Adoption Act of 2000, Pub. L. No. 106-279, 114 Stat. 825 (2000), 42 U.S.C. § § 14901 to 14954.

(f) ORS chapter 109.

(3) Policies and procedures designed to ensure that the decision to place a child in care in a specific home or to disrupt a placement is not made autonomously by a social services worker.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0431
Records Requirements for Adoptions

In addition to compliance with the records and documentation requirements of OAR 413-215-0071 and 413-215-0456:

(1) Permanent record in a domestic adoption. An adoption agency must maintain a permanent record on each birth parent who has consented to and has surrendered a child in care to the adoption agency. Except as authorized by section (2) of this rule, the record must include all of the following documents or information:

(a) The date and place of the birth parent's initial inquiry with the adoption agency and the persons present when the inquiry was made.

(b) The date, place, and purpose of each subsequent contact between the adoption agency and the birth parent.

(c) Evidence that the following adoption agency forms were provided to the birth parent:

(A) Consent for Service;

(B) Receipt of Grievance Procedures;

(C) Clients' Rights and Responsibilities, including the notice required by ORS 109.346 when applicable; and

(D) Service Plan.

(d) Each alternative to adoption discussed with the birth parent.

(e) A description of each discussion relating to fees, expenses, or other consideration or thing of value relating to the adoption.

(f) The date, time, and place of birth of the child in care, the name and address of the hospital or birthing center if the child in care was born in one, and all pertinent prenatal information.

(g) The names, dates of birth, physical description of the birth parents at the time of the child in care's birth, including age, height, weight, and color of eyes, hair and skin.

(h) Personality traits of the child in care's birth parents, siblings, and members of the child's extended family.

(i) A medical history of the birth parents, siblings, and extended family of the child in care, including medical, mental, and emotional history, including the history of the use of drugs or alcohol, gynecologic and obstetric history of the birth mother, and a record of inheritable genetic or physical traits or tendencies of the birth parents or their families.

(j) The ethnicity of the child in care's birth parents and the members of the child's extended family.

(k) Documentation of the efforts of the adoption agency to determine whether the Indian Child Welfare Act (ICWA) applies.

(l) The religious background of the child in care's birth parents and the members of the birth parents' extended family.

(m) The educational level and functioning, employment history, criminal history, and social and emotional functioning of the birth parents, siblings, and the members of their extended family.

(n) A notation that identifies the adoptive parents sufficient to cross-reference the file of the adoption agency on the adoptive parents.

(o) A copy of the placement agreement.

(p) Post-adoption communication agreements.

(q) Details about any termination of parental rights.

(r) A copy of the general judgment of adoption.

(s) Copies of any documents signed by the birth parent.

(2) If the adoption agency is unable to include in the permanent record a document or information required by subsections (1)(f) to (1)(m) of this rule, the adoption agency must include in the record a description of its reasonable effort to obtain the document or information.

(3) Preservation and retention of adoption records for adoptions. An adoption agency giving legal consent to the adoption of a child in care must permanently retain, to the extent allowed by law, the records concerning the child's adoption, as follows:

(a) The record must include all of the following:

(A) Adoptive parent orientation documentation.

(B) Evaluation documentation of both the birth and adoptive parents.

(C) Placement documentation.

(D) Post-placement supervision documentation.

(E) Originals of photographs, letters, and other personal items provided by the child in care's birth family.

(b) The adoption agency must store the records in fire-retardant, locked files kept in a secure location.

(c) If more than one adoption agency is involved in an adoption, the adoption agency that placed the child in care must preserve the permanent case record.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 109.342, 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0436
Services Prohibited

An adoption agency may not guarantee or represent to prospective adoptive parents that a particular child in care will be placed in their home for payment of a fee.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 109.342, 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0441
Services for Birth Parents Considering Domestic Adoption

(1) If an adoption agency is serving a birth parent who is considering the adoption of his or her child:

(a) The adoption agency must provide the services described in these rules, OAR 413-215-0401 to 413-215-0481.

(b) If the adoption agency is serving a birth parent who lives in a state other than Oregon, the adoption agency must make the services described in these rules (OAR 413-215-0401 to 413-215-0481) available to the birth parent in the state of residence of the birth parent.

(2) Information.

(a) The adoption agency must make reasonable efforts to provide information described in subsection (2)(c) of this rule to each legal parent.

(b) The adoption agency must make reasonable efforts to provide information described in subsection (2)(c) of this rule to a putative father if:

(A) The putative father resided with the child in care within 60 days of the court proceeding about the adoption or custody of the child in care;

(B) The putative father repeatedly contributed or tried to contribute to the support of the child in care within 12 months of the court proceeding about the adoption or custody of the child in care; or

(C) There is a notice of initiation of filiation proceedings on file with the Center for Health Statistics of the Department prior to the initiation of either a court proceeding about the adoption or custody of the child in care, or the placement of the child in the physical custody of a person for the purpose of adoption by them. There is no requirement to provide information under this paragraph if the notice of initiation of filiation proceedings was not on file at the time of placement.

(c) The adoption agency must provide all of the following information to the persons identified in subsections (2)(a) and (2)(b) this section:

(A) Information regarding support and resources needed to parent a child in care.

(B) Information regarding options within adoption and the consequences of each option, including the possibility of a birth parent continuing contact with the adopted child in care and the adopting parents after adoption, the variables and options for such continuing contact, the desire of the child in care for continuing contact, and the availability of mediation to resolve issues involving contact.

(C) Information regarding grief and loss inherent in adoption.

(D) Information regarding the effects and permanence of adoption.

(E) Information regarding availability of or referral to appropriate support services. The availability of these services may not be made contingent upon the birth parent's decision to select adoption as the plan for the child in care.

(3) The adoption agency must provide guidance if a child in care's birth parents disagree with each other about the adoption plan.

(4) Identification of birth fathers. If the adoption agency is working with a birth mother, the adoption agency must ensure all of the following:

(a) The adoption agency asks the birth mother for the identity and whereabouts of the birth father.

(b) The adoption agency does not counsel or advise a birth mother to state that the identity or location of the father is unknown.

(c) If the birth mother indicates that the identity or location of the father is unknown, or if the birth mother refuses to identify the birth father, the adoption agency advises her of the potential ramifications of her knowing failure to provide the information.

(d) The adoption agency must contact the Center for Health Statistics of the Department within a reasonable period of time prior to placement to

determine whether the child in care's legal or putative father can be identified.

(e) The adoption file of the adoption agency includes all reported information about the legal or putative father, even if his identity or location is unknown to the mother.

(5) Disclosures prior to placement:

(a) Potential disclosure of parental identity. The adoption agency must tell each birth parent who is contemplating making their child available for adoption that information related to their identities may subsequently be disclosed to the child in care in accordance with Oregon law.

(b) Voluntary adoption registry. As required by ORS 109.353, the adoption agency must inform each birth parent of the voluntary adoption registry established under ORS 109.450.

(c) Adoption–related counseling for birth parents. As required by ORS 109.346, the adoption agency must provide notice to each birth parent consenting to an adoption regarding his or her right to adoption-related counseling.

(6) Consent and surrender. The adoption agency may accept the voluntary consent and surrender of a child in care after taking all of the following actions:

(a) Providing to each birth parent full and accurate information, and the opportunity to discuss the consequences of the documents they are signing.

(b) Discussing with each birth parent the circumstances leading to the decision to choose adoption.

(c) Informing each birth parent of their right to their own legal counsel at their own expense.

(d) Providing each birth parent with written information to assist them in understanding the changes that result from adoption in their parental legal rights, obligations, and responsibilities, including potential ramifications of post-placement establishment of paternity.

(e) After the birth of the child in care, reassessing the birth mother's ability to understand the consequences of her decision to sign a consent and surrender document. This assessment must include consideration of her emotional state and current influence of medication.

(f) In the case of an Indian child, informing the parents that if no different order of preference has been established by the child in care's tribe for adoptive placement, the adoption agency must, in the absence of the court's determination that good cause to the contrary exists, give preference to placing the child in care with a member of the child in care's extended family, other members of the Indian child's tribe, or other Indian families.

(g) Informing the birth parent that the adoption agency cannot honor a request of the birth parent to place the child in care with a family based solely on preferred race, color, or national origin unless the child is an Indian child in care, in which case the licensed agency must follow the Indian Child Welfare Act of 1978.

(7) Documents. The adoption agency must provide a copy of all documents signed by the birth parents to the birth parents at the time they sign a consent and surrender document.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 109.096, 109.346, 109.353, 418.205 - 418.310, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-94, cert. ef. 12-29-95; Renumbered from 413-220-0050, CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0446
Adoptive Family Recruitment and Screening

An adoption agency must have a recruitment and screening process that meets all of the following standards:

(1) The adoption agency must have an ongoing recruitment program to ensure an adequate number of suitable adoptive families are identified for the types of children in care identified in the program statement of the adoption agency.

(2) Orientation. The adoption agency must provide orientation for the adoptive family before the adoption agency approves the home study. The orientation must include the following information:

(a) The adoption program, policies, and procedures of the adoption agency.

(b) The needs and characteristics of children available for adoption.

(c) Attachment, separation, and loss issues for children and families.

(d) The importance of cultural and ethnic identity to the child in care and ways to foster these identities.

(e) The effects of adoption on the child in care and family.

(f) The adoption process.

(g) Rights and responsibilities of the adoptive family and adoption agency.

(h) Information on the potential risks and challenges inherent in adoption.

(i) Pre-placement, placement, and post-legal adoption services and resources available to the adoptive family.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0451
Adoptive Home Requirements

(1) Home study. Before an adoption agency approves a family for an adoptive placement and before referring or placing a child in care with a family for the purpose of adoption, a social services worker must complete a written home study of the adoptive family. The home study must include all of the following:

(a) An individual interview with each applicant parent as well as with each member of the applicants' household, as applicable.

(b) If the applicants are married or are a cohabiting couple, an additional, joint interview with the couple.

(c) An on-site evaluation of the applicants' home to determine whether the home is in full compliance with the safety standards identified in the Safety Checklist (CF 979).

(2) Written home study. The home study required by section (1) of this rule must include all of the following information:

(a) The dates and places in which applicant parent and household members were interviewed or observed.

(b) The identity of each child in care to be considered for placement, if known.

(c) The applicants' motivation for adoption.

(d) The family's plan for honoring the child's ethnic and cultural heritage.

(e) Education or training needs of the adoptive parents, including education and training for children in care having special needs.

(f) The applicants' need for support services and description of current support system.

(g) Life experiences and challenges of the applicants.

(h) Marriage status or relationship of the applicants.

(i) The names and ages of the applicants' children in the home.

(j) The names and ages of the applicants' children not living in the home.

(k) The applicants' parenting skills and values.

(l) The applicants' lifestyle.

(m) The applicants' home and community.

(n) The applicants' health.

(o) The applicants' religion or spiritual beliefs, as applicable.

(p) The applicants' employment and finances.

(q) Safety information and safety issues discussed with the applicants.

(r) Minimum of four references not related to the applicants.

(s) Comply with the Department's background check rules at OAR 407-007-0200 to 407-007-0370.

(t) Criminal history check and a child abuse and neglect history from every state in which the individual has lived within the preceding five years for each member of the household age 18 or older. Checks are also required for a household member under the age of 18 if there is reason to believe that the household member may pose a safety threat to children placed in the home.

(u) Documentation that a child abuse and neglect history was requested from any other country in which a member of the household age 18 or older has lived within the preceding five years, and the response if any.

(v) An assessment of all the information gathered regarding the adoptive applicants and any recommendations.

(w) Signed approval or denial by a social services supervisor to use the home for adoption.

(3) Home study requirements.

(a) An adoption agency may not complete a home study until the prospective adoptive parents have received at least six hours of the pre-adoptive training and education required by OAR 413-215-0456.

(b) An adoptive home study is valid for a maximum of two years from the date of completion, providing significant changes have not occurred in the applicants' household.

(c) If significant changes occur in the applicants' household after the completion of the home study but before the adoption is finalized, the adoption agency must complete an update of the home study.

(d) Once the adoption is finalized, the adoption agency must complete a new home study each time the family seeks to adopt another child in care.

(4) Certificate of approval. The adoption agency must issue a written document certifying the approval or disapproval of the applicants as potential adoptive parents.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0456
Information, Education, and Training for Adoptive Parents

An adoption agency must meet all of the following requirements related to information, education, and training for adoptive parents:

(1) Adoptive parent training. The adoption agency must document that it has provided the prospective adoptive parents a minimum of 10 hours of comprehensive orientation and training, independent of the home study, that covers all of the following:

(a) The possible short- and long-term effects of prenatal exposure to alcohol, drugs, and poor nutrition.

(b) The effects of separation and loss.

(c) The process of developing emotional ties to an adoptive family.

(d) Normal child and adolescent development.

(e) What research indicates about the potential effect on a child in care's development of physical abuse, sexual abuse, neglect, institutionalization, and multiple caregivers.

(f) Issues related to race, culture, and identity.

(g) Acculturation, assimilation, and, if applicable, the effects of having been adopted internationally.

(h) Emotional adjustment of adopted children and their families, including attachment and psychological issues of adopted children who have experienced abuse, neglect, or trauma.

(i) In the case of an intercountry adoption, the process involved in an intercountry adoption and the general characteristics and needs of children awaiting intercountry adoption.

(2) Individual preparation. The adoption agency must document reasonable efforts to prepare prospective parents for the adoption of each child in care under consideration before the earliest of the following:

(a) The child in care is placed with them.

(b) Travel to the child in care's country for the purpose of adoption.

(3) Methods of training.

(a) The adoption agency must provide the required training using appropriate methods, such as:

(A) Collaboration among agencies or persons to share resources to meet the training needs of parents;

(B) Group seminars offered by the adoption agency or others who provide training;

(C) Individual counseling sessions;

(D) Video, computer-assisted, or distance learning methods using standardized curricula.

(b) If the training cannot otherwise be provided, the adoption agency may allow the prospective adoptive family to complete an independent study that includes a system for evaluating the thoroughness of the subjects covered.

(4) Information and disclosures.

(a) The adoption agency must give the adoptive family detailed written information covering the following subjects:

(A) Resources for financial support, including tax credit, employee adoption benefit programs, and other financial assistance.

(B) Medical assistance availability, as applicable.

(C) Support services available to the family and the adoptive child, including adoptive family support groups, educational workshops and conferences, individual and family counseling, mental health services, and respite care.

(D) Information identifying each organization or individual who will be involved in the proposed placement, including whether the organization or individual will derive a fee or other consideration from a source other than the client in connection with the adoption.

(E) In domestic adoptions only, the potential ramifications of a failure of the birth father to sign the consent and surrender documents.

(b) If a child in care qualifies for adoption assistance through the department's Adoption Assistance Program, the adoption agency must assist the prospective adoptive parents in getting approvals or agreements in a timely manner, prior to adoption finalization.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-94, cert. ef. 12-29-95; Renumbered from 413-220-0070, CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0461
Evaluation and Selection of Adoptive Family

An adoption agency must meet all of the following requirements regarding the placement of a child in care:

(1) Pre-placement evaluation. A social services worker must review the record, evaluate, and document all of the following factors before making a placement with an adoptive family:

(a) Physical, emotional, social, behavioral, educational, and other individual needs of the child in care.

(b) The child in care's need for continued contact with siblings, relatives, foster parents, and other persons significant to the child in care.

(c) The ability and willingness of the prospective adoptive parents to accept the general and specific risks and challenges inherent in the placement being considered.

(2) Placement requirements. For the placement of a child in care, the adoption agency must select an adoptive family who is approved by an adoption agency, consistent with the needs of the child in care and the recommendations in the pre-placement evaluation.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0466
Domestic Adoptive Placement; Adoption Agency Requirements

An adoption agency must meet all of the following requirements related to a domestic placement:

(1) Pre-placement visit. The adoption agency must develop a written transition plan based on the developmental needs and best interests of the child in care. The plan must include provisions for pre-placement visits with the prospective adoptive family.

(2) Placement agreement documents. Before placing the child in care in a home, the adoption agency must have a written agreement with the pre-adoptive parents. A signed copy of this agreement must be given to the pre-adoptive parents and a copy must be placed in the case record. The agreement must specify the following, if appropriate:

(a) That the pre-adoptive parents agree to legally finalize the adoption in a time frame that is based on the best interests of the child in care;

(b) That the adoption agency will provide the documents necessary for finalizing the adoption in a time frame that is based on the best interests of the child in care;

(c) That the pre-adoptive parents agree to participate in supervision by the adoption agency, based on the best interests of the child in care, during the time prior to finalization of the adoption;

(d) That the pre-adoptive parents agree to provide written notification to the adoption agency prior to each of the following:

(A) A change of residency.

(B) The removal of the child in care from the state for more than 72 hours.

(C) Placement of the child in care in the care of another person for more than 72 hours.

(e) That the adoption agency will arrange for supervision in accordance with the Interstate Compact for Placement of Children if the adoptive family moves to another state.

(f) The plan must address all of the following subjects, based on the best interests of the child in care, in the event of a disruption:

(A) Who has responsibility for providing care and the cost of care.

(B) Financial arrangements to ensure transfer of custody when necessary.

(C) For intercountry adoptions only, whether the child in care is to remain in the country of placement and how the authorities in the originating country will be notified of the disruption.

(3) Medical consent form. At the time of the child in care's placement in the adoptive home, the adoption agency must give the adoptive parents a signed medical consent form authorizing medical care of the child in care.

(4) Child and birth parent information. Before placing a child in care with a family, the adoption agency must make reasonable efforts to discuss with the adoptive parents and provide them in writing all available information about the child in care and his or her birth parents, including, but not limited to:

(a) Medical data.

(b) Information about genetic, congenital, or pre-existing conditions.

(c) Information on the child in care's physical, emotional, and behavioral functioning and adjustment

(d) Pertinent information regarding the birth parents, excluding identity.

(e) Information about disabilities and their implications, including information from diagnosticians and, if applicable, appropriate therapists.

(5) The adoption agency may not withhold or misrepresent information, nor may it misrepresent the implications of child information. The adoption agency and its agents must provide to prospective adoptive parents, in accordance with these rules (OAR 413-215-0401 to 413-215-0481), all information obtained about the child in care.

(6) Post-placement supervision. The adoption agency is responsible for the child in care until the court has entered the general judgment of adoption. After the child in care is placed, the adoption agency must provide and document supervision of the home by a social services worker, including all of the following:

(a) A home visit with the family within the first 30 days following placement to establish a helping post-placement relationship. The frequency of contacts, including home visits, office visits, telephone calls, and e-mail, is dependent on the child in care's age and special needs, and the family's adjustment to the child in care.

(b) Any change in the adoptive family relating to health, finances, or composition that could affect the child in care.

(c) Providing to the adoptive parents any medical information on a child in care's birth family received by the adoption agency after the child in care was placed for adoption.

(d) If the placement appears likely to disrupt, the adoption agency must document its efforts to:

(A) Provide counseling services to preserve the placement; and

(B) Provide or arrange for replacement services, including foster care if needed, if disruption occurs.

(7) Post-legalization services. The adoption agency must make adoption services available to birth parents, adoptive parents, and adopted children after the adoption is finalized. The adoption agency must provide or inform the adoptive parents how to obtain information regarding all of the following:

(a) Counseling services.

(b) Crisis intervention.

(c) Respite care.

(d) Specialized support groups.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106

Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106

Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0471

Adoption Finalization — Adoption Agency Requirements

(1) For the legal finalization of an adoption, an adoption agency must prepare and promptly provide to the adoptive family or the family's attorney all documents required for filing with the court.

(2) After consenting to the adoption of a minor child, an adoption agency must promptly file with the appropriate court all required documents that are available.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106

Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106

Hist.: SCF 6-1995, f. 12-22-94, cert. ef. 12-29-95; Renumbered from 413-220-0080, CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0476

Intercountry Adoptions

In addition to the requirements for adoption agencies in OAR 413-215-0401 to 413-215-0481 other than OAR 413-215-0431(1) - (2), 413-215-0441, 413-215-0456(4)(a)(E), and 413-215-0466, an adoption agency approved to provide intercountry adoptions must meet all of the following standards with regard to intercountry adoptions:

(1) Compliance with foreign law.

(a) The adoption agency must comply with the laws and regulations of the sending country.

(b) The adoption agency must make reasonable efforts to learn and understand legal and procedural adoption requirements in the sending country.

(c) The adoption agency must establish written policies and procedures designed to fulfill and comply with the legal requirements, adoption laws, and adoption procedures of the sending country.

(d) The adoption agency must train its employees and volunteers about the adoption laws and procedures of the sending country.

(2) Compliance by foreign representatives. If the adoption agency uses an organization or person in the foreign country to facilitate adoption services within the foreign country, the adoption agency must make reasonable efforts to see that the organization or person meets all of the following requirements:

(a) Fully complies with all adoption and other laws and procedures of the sending country.

(b) Is licensed or otherwise authorized to provide the contemplated adoption services within the sending country.

(c) Does not engage in practices that are not in the best interests of the child in care or that encourage or facilitate the sale, abduction, exploitation, or trafficking of children.

(d) Does not have a pattern of licensing suspensions or other sanctions within the foreign country and has not lost the right to provide adoption services in any jurisdiction for reasons associated with unlawful or unethical service.

(e) Provides full disclosure to the adoption agency regarding any suspension, debarment, sanction, criminal charge, or disciplinary action against the organization or person, or any person serving with the organization, related to adoption services or financial dealings within the past ten years.

(f) Provides full disclosure to the adoption agency of business activities performed by or engaged in by employees or affiliates of the foreign representative that are inconsistent with the principles of these rules or the Intercountry Adoption Act of 2000, 42 U.S.C. 14901 to 14954.

(3) Pre-placement determination of compliance. Before a child in care can be placed for adoption, the adoption agency must determine that the adoption service or person authorized by the sending country has certified that:

(a) The child in care is qualified for adoption and is in the permanent custody of an authorized organization or person in the sending country.

(b) The authorized service or person has obtained proof from a competent authority in the child in care's country of origin that the necessary consents to the child in care's adoption have been obtained and that the necessary determination has been made that the prospective placement is in the best interests of the child in care.

(c) The child in care has the proper emigration and immigration permits.

(d) The authorized service or person has the child in care's social and medical history or, if either is not available, has documented adequate reasons why the adoption agency was not able to obtain the information.

(4) Child information requirements. The adoption agency must use reasonable efforts, or require the authorized organization or person in the child in care's country of origin to make reasonable efforts, to obtain and provide all available information concerning a child in care referred for adoption, if known to the adoption agency or foreign representative, including the all of following:

(a) The date an authorized authority in the sending country took custody of the child in care and the reasons why the child in care is in custody.

(b) Information concerning the child in care's history, including a chronology showing the persons and institutions that have had custody of and cared for the child in care, the nature of care provided, and the reasons for transferring custody.

(c) Information concerning the child in care's immediate family, including current status and location of the birth parents and siblings of the child in care; history of abuse, neglect, or mistreatment of the child in care; history of alcohol and drug abuse by the birth parents; hereditary conditions; and other risk factors.

(d) Information concerning the child in care's cultural, racial, religious, ethnic, and linguistic background.

(e) The child in care's medical information, including all of the following:

(A) All medical records, including both summaries or compilations of medical records and original records.

(B) Information resulting from medical examinations of the child in care.

(C) A history of significant illnesses or medical events, hospitalizations, and changes in the child in care's condition, growth data, and developmental status at the time of the child in care's referral for adoption.

(f) Videotapes and photographs of the child in care, identified by the date on which the videotape or photograph was recorded or taken.

(g) Specific information regarding health risks in the specific region or country where the child in care resides.

(5) An adoption agency must provide the information described in section (4) of this rule to prospective adoptive parents regarding a child in care referred for adoption as follows:

(a) The information must be provided at least two weeks before the earliest of the following:

(A) The adoption or placement for adoption.

(B) The date on which the prospective adoptive parents travel to the sending country to complete procedures relating to the adoption.

(b) To the extent the matter is within its control, the adoption agency may not withdraw the referral of a child in care until the prospective adoptive parents have had at least one week to consider the needs of the child in care and their ability to meet those needs, and to obtain medical review of child in care information. The adoption agency may withdraw the referral earlier if the best interests of the child in care require a more expedited decision.

(c) The information must be provided in both the original language, if available, and in English. The adoption agency must do nothing to discourage prospective adoptive parents from obtaining their own translation of the information.

(6) An adoption agency must document in its adoption file all of the following:

(a) The efforts of the adoption agency to obtain the information.

(b) Reasons why the adoption agency was not able to obtain the information, if applicable.

(c) All communications made with prospective adoptive parents regarding the information, including contents of, dates, and the manner in which the information was provided to the prospective adoptive parents.

(7) With regard to post-placement and post-legalization requirements and services, an adoption agency must meet all of the following requirements:

(a) The adoption agency must take all appropriate measures to ensure that the transfer of the child in care takes place in secure and appropriate circumstances, with properly trained and qualified escorts, if used, and, if practicable, in the company of the adoptive parents.

(b) Until the adoption is finalized, the adoption agency must provide post-placement reports on a child in care to the sending country when required by the sending country. When such reports are required, the adoption agency:

(A) Must inform the prospective adoptive parents of the requirement prior to the referral of the child in care for adoption; and

(B) Must inform the prospective adoptive parents that they will be required to provide all necessary information for the reports.

(c) For children in care sent to the United States, in addition to post-placement reports required by the sending country, the adoption agency must require at least one home visit with all persons living in the adoptive home between one and four months after the child in care's arrival in the United States. Home visits must be documented in a post-placement report that includes all of the following issues:

(A) The status and adjustment of each child in the adoptive home.

(B) The status and adjustment of the prospective adoptive parents and other adoptive family members to each child in care placed in the home.

(C) A summary of the information obtained concerning the birth parents and the available social, medical, and genetic history of each child in care placed in the home.

(d) If an adoption or re-adoption is sought in Oregon, the original post-placement report, along with recommendations, must be filed by the adoption agency with the court and a copy forwarded to the department.

(e) The adoption agency must inform the prospective adoptive parents of other available post-placement services and resources, including all of the following:

(A) Additional home visits, office visits, telephone conferences, and other contacts with the personnel of the adoption agency.

(B) Other professionals, organizations, and groups that provide support and information for adoptive parents of children adopted internationally.

(f) When an adoption is not finalized in the sending country, the adoption agency must meet all of the following requirements:

(A) Monitor and supervise the placement to ensure that the placement remains in the best interests of the child in care.

(B) Inform prospective adoptive parents of the importance of finalizing the adoption in the United States and contractually require the prospective adoptive parents to finalize the adoption in the United States within a specified period after receiving the consent of the adoption agency for adoption.

(C) Advise adoptive parents regarding the means of obtaining proof of citizenship for the child in care and the process for obtaining a social security number.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-94, cert. ef. 12-29-95; Renumbered from 413-220-0100, CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0481

Services to Children from the United States Placed in Other Countries

Before making a plan to place a child in care from the United States with non-relative citizens of another country, an adoption agency must make reasonable efforts to actively recruit and make a diligent search for prospective adoptive parents in the United States.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 32-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0501

Residential Care Agencies; What Law Applies

These rules, OAR 413-215-0501 to 413-215-0586, regulate a child-caring agency licensed as a residential care agency. A residential care agency must also comply with OAR 413-215-0001 to 413-215-0131.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0000, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0506

Definitions

When used in OAR 413-215-0501 to 413-215-0586:

(1) "Age-appropriate or developmentally appropriate activities" means:

(a) Activities or items that are generally accepted as suitable for children or young adults of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child or young adult, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and

(b) In the case of a specific child, activities or items that are suitable for the child or young adult based on the developmental stages attained by the child or young adult with respect to the cognitive, emotional, physical, and behavioral capacities of the child or young adult.

(2) "Care" means services provided to meet the needs of a child, such as food, shelter, clothing, medical care, schooling, protection, and supervision.

(3) "Child" means an unmarried person under 18 years of age.

(4) "Employee" means an individual holding a paid position with a residential care agency.

(5) "Facility" means the physical setting, buildings, administration, staff, equipment, and program of a residential care agency.

(6) "Family" means related members of a household, among whom at least one adult functions as a parent to one or more minor children.

(7) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance either internally or externally by any person.

(8) "Reasonable and prudent parent standard" means the standard, characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child or young adult while encouraging the emotional and developmental growth of the child or young adult, that a substitute care provider shall use when determining whether to allow a child or young adult in substitute care to participate in extracurricular, enrichment, cultural, and social activities.

(9) "Resident" means any child residing in a residential care agency other than an infant who resides with an adolescent parent.

(10) "Residential" means care or treatment services provided on a 24 hour per day basis to children. For the purpose of these rules, "residential care or treatment" does not include services provided in family foster homes or adoptive homes.

(11) "Residential care agency" means a private child-caring agency (defined in OAR 413-215-0006) that provides services to children 24 hours a day.

(12) "Staff" means employees of the residential care agency who are responsible for providing direct care or treatment to residents.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327
Stats. Implemented: ORS 418.205 - 418.327
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0010, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0511

Physical Plant Requirements

(1) A residential care agency may not allow children in care to have access to, or provide services regulated by these rules (OAR 413-215-0501 to 413-215-0586) in, a building unless the building has been certified as meeting all applicable state and local construction-related requirements for a building used as a residential facility, including: the Oregon Structural

Specialty Code (see the current version of OAR 837-040-0140), the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020), Oregon Health Authority Public Health Division (see the current requirements for buildings in OAR chapter 333), the Oregon Plumbing Specialty Code (see the current version of OAR 918-750-0110 to OAR 918-750-0140), the rules of the State Fire Marshal (see the current requirements for buildings in OAR chapter 837), and the local building, fire, and safety codes.

(2) A residential care agency must ensure that all of the following standards are met:

(a) All buildings where children in care are present must be smoke-free.

(b) Water temperature and access to water:

(A) A continuous supply of hot and cold water, installed and maintained in compliance with this rule and OAR 413-215-0516, must be distributed to taps conveniently located throughout each building used to provide services or housing for children in care.

(B) The temperature of hot water used for hand washing, bathing, or showering must be controlled so that it does not exceed 120 degrees Fahrenheit in each building used to provide services or housing for children in care.

(C) Each child in care who lacks the ability to adjust and control water temperature safely must be directly supervised by a staff member of the residential care agency.

(c) Heating and ventilation. Room temperatures must be maintained within normal comfort range. Buildings must be ventilated and free of excessive heat and condensation and unpleasant odors.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 106
Hist.: CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0516
Room and Space Requirements

A residential care agency must meet all of the following room and space requirements:

(1) All parts of the facility must ensure the safety of the children in care.

(2) All areas of the facility must be kept clean and in good repair. Major Appliances and heating, ventilation, plumbing, and electrical systems must be functional and in good repair.

(3) Living area. A separate living room or lounge area must be available for the exclusive use of residents, employees, and invited guests with a minimum of 15 square feet per child in care.

(4) Bedrooms. Bedrooms for children in care may not be exposed to drafts, odors, or noises that interfere with the health or safety of the occupants. Each bedroom must comply with all of the following requirements:

(a) Have adequate furnishings and personal items for the children in care residing in them.

(b) Be separate from the rooms used for dining, living, multi-purpose, laundry, kitchen, or storage.

(c) Be an outside room, with a window allowing egress from the building.

(d) Have a ceiling height of at least 90 inches.

(e) Have a minimum of 60 square feet per bed.

(f) House no more than 25 children in care in one room when a dormitory-style sleeping arrangement is used.

(g) Have permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(h) Have a window covering on each window to ensure privacy.

(i) Contain beds for children in care that meet both of the following requirements:

(A) There must be at least three feet between beds, including trundle beds if used; and

(B) Bunk beds, if used, must be maintained to ensure safety of the children in care.

(5) Bathrooms.

(a) Bathrooms must be provided and be conveniently located in each building containing a child in care's bedroom, and must have all of the following:

(A) A minimum of one toilet and one hand-washing sink with mixing faucets for each eight children in care.

(B) A self-closing metered faucet, if used, that provides water flow for at least 15 seconds without a need to reactivate the faucet.

(C) Hot and cold running water, as well as soap and paper towels available at sinks, or, other hand-drying options approved by the local health department.

(D) One bathtub or shower for each ten children in care.

(E) Arrangements for individual privacy for each child in care.

(F) A window covering on each window to ensure privacy.

(G) Permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(H) Adequate ventilation.

(I) Have adequate personal items for children in care.

(b) Use of wooden racks over shower floors is prohibited.

(c) When impervious shower mats are used, they must be disinfected and dried at least once per day.

(6) Dining area. A separate dining room or area must be provided for the exclusive use of children in care, employees, and invited guests. The dining area must have the capacity to seat at least one-half of the children in care at one time and must contain a minimum of 15 square feet per child in care.

(7) Kitchen.

(a) Kitchens must be used exclusively for storage, food preparation, dish washing, and other activities related to eating and may not, except as provided in OAR 413-215-0536, be used for children in care's activities other than eating.

(b) The walls, floors, and floor coverings of all rooms in which food or drink is prepared or stored or utensils are washed or stored must be smooth, washable, and easily cleanable.

(c) All equipment and utensils used for food service, including plastic ware and food-contact surfaces, must be easily cleanable, durable, nontoxic, and nonabsorbent, and must be maintained in a clean and sanitary condition.

(d) All equipment used for food preparation must be installed and maintained in a manner that provides ease of cleaning beneath, between, and behind each unit.

(8) Laundry area. Laundry facilities, when provided, must be separate from all of the following:

(a) Living areas, including bedrooms for children in care.

(b) Kitchen and dining areas.

(c) Areas used for the storage of un-refrigerated perishable food.

(9) Storage. Separate storage areas must be provided for each of the following:

(a) Food, kitchen supplies, and utensils.

(b) Clean linens.

(c) Soiled linens and clothing.

(d) Cleaning compounds and equipment.

(e) Poisons, chemicals, pest and rodent control products, insecticides, and other toxic materials that must be properly labeled, stored in the original container, and kept in a locked storage area.

(f) Outdoor recreational and maintenance equipment.

(10) Outdoor activity area. A usable out-of-doors activity area must be provided that is protected from vehicular traffic and other hazards. The area must be of sufficient size to meet the recreational needs of the children in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0100, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0521
Resident Furnishings and Personal Items

A residential care agency must meet all of the following requirements:

(1) Furniture. Adequate furniture must be provided for each child in care including, but not limited to:

(a) A bed, including a frame;

(b) A clean, comfortable mattress and a pillow; and

(c) A private dresser, closet, or similar storage area for personal belongings that is readily accessible to the child in care.

(2) Linens. Linens in good repair must be provided or arranged for each child in care, including:

(a) A waterproof mattress cover or waterproof mattress;

(b) Sheets and pillowcase;

(c) Blankets appropriate in number and type for the season and the individual resident's comfort; and

(d) Towels and washcloths.

(3) Bedding must be changed when soiled and upon change of the child in care using the bedding.

(4) Personal hygiene supplies. Individual personal hygiene supplies that are appropriate to the child's age, gender, and culture must be made available to each child in care, stored in a clean and sanitary manner, and must include:

(a) A comb;

(b) Shampoo, or other hair cleansing product;

(c) A toothbrush;

(d) Soap;

(e) Deodorant;

(f) Toothpaste;

(g) Toilet paper;

(h) Menstrual supplies, if appropriate; and

(i) Other supplies that are appropriate to the child in care's age, gender, and cultural needs.

(5) Clothing. Adequate and seasonally appropriate clothing must be provided for the exclusive use of each child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0130, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0526
New Facility or Remodel

A residential care agency must meet all of the following requirements:

(1) Building plans.

(a) A residential care agency must submit to the Department for approval a set of plans and specifications for each residential care facility operated by the residential care agency at each of the following times:

(A) Prior to construction of a new building.

(B) Prior to construction of an addition to an existing building.

(C) Prior to the remodeling, modification, or conversion of a building.

(D) In support of an application for initial license to operate as a residential care agency.

(b) Plans must comply with all applicable state and local requirements for a building used as a residential facility, including the Oregon Structural Specialty Code (see OAR 837-040-0140), the Oregon Fire Code (see OAR 837-040-0010 and 837-040-0020), Oregon Health Authority requirements for buildings (see OAR chapter 333), the Oregon Plumbing Specialty Code (see OAR 918-750-0110 to OAR 918-750-0140), the rules of the State Fire Marshal for buildings (OAR chapter 837), and the local building, fire, and safety codes.

(c) Plans must be drawn to scale, and must specify the date upon which construction, modification, or conversion will be completed, if applicable.

(2) Sanitarian approval. The water supply, sewage, and garbage disposal systems must be approved by a sanitarian registered with the Environmental Health Registration Board (see OAR 338-010-0025 to 338-010-0038).

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0531
Environmental Health

A residential care agency must meet all of the following requirements:

(1) The program of the residential care agency must maintain an environment that ensures safety for program staff and children in care.

(2) Environmental Health Specialist approval. Prior to licensure and every two years upon license renewal, the program must be assessed and provide documentation of approval by a registered environmental health specialist (see OAR 338-010-0025 to 338-010-0038) for the following safety areas:

(a) Food service risk assessment.

(b) Drinking water or waste water assessment.

(c) Vector and pest control, including the use of pesticides and other chemical agents.

(d) Hazardous material management, including handling and storage.

(e) Recreation assessments (such as playgrounds, swimming pools, and hot tubs) for injury prevention and hazard mitigation.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0120, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0536
Food Services

A residential care agency must meet all of the following requirements with regard to food services:

(1) Nutrition and dietary requirements.

(a) A residential care agency must arrange meals daily, consistent with normal mealtimes that occur during hours of operation.

(b) Menus must be prepared in advance in accordance with USDA guidelines and must provide a sufficient variety of foods served in adequate amounts for each child in care at each meal, adjusted for seasonal changes. Records of menus as served must be maintained in the record of the residential care agency for at least six months.

(c) Drinking water must be freely available to the children in care served by the residential care agency.

(2) Food selection, storage, and preparation.

(a) All food and drink provided by the residential care agency must be stored, prepared, and served in a sanitary manner.

(b) All employees who handle food served to children in care must have a valid food handlers card pursuant to ORS 624.570.

(c) Selection of food. All food products served by a residential care agency must be obtained from commercial suppliers, except:

(A) Fresh fruits and vegetables and fruits or vegetables frozen by the residential care agency may be served.

(B) The serving of un-pasteurized juice is prohibited.

(d) Requirements related to milk.

(A) Only Grade A pasteurized and fortified milk may be served to children in care.

(B) Milk and fluid milk products must be dispensed from a commercially-filled plastic container of not more than one-gallon capacity or from a refrigerated bulk container equipped with a dispensing device approved by the Food and Drug Administration or Oregon Department of Agriculture.

(e) Children in care may participate in activities in a food-preparation area, other than routine clean up, only while under the supervision of the employees of the residential care agency.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0150, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0541
Safety

A residential care agency must meet all of the following requirements related to safety:

(1) Fire safety. Prior to licensure and every two years upon license renewal, the program must be assessed and approved by the State Fire Marshall or designee for the following fire safety areas:

(a) The residential care agency must provide fire safety equipment that meets the requirements of applicable building codes and the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020).

(b) The residential care agency must comply with existing state and local fire safety codes.

(2) Emergency plan.

(a) The residential care agency must have, for each facility it operates, a written emergency plan that includes:

(A) Instructions for evacuation of children in care and employees in the event of fire, explosion, accident, or other emergency.

(B) Instructions for response in the event of a natural disaster, external safety threat, or other emergency.

(b) Telephone numbers for local police and fire departments and other appropriate emergency numbers must be posted near all telephones.

(c) Operative flashlights sufficient in number must be readily available to the staff in case of emergency.

(3) Evacuation drills.

(a) An unannounced evacuation drill must be held monthly under varying conditions to simulate the unusual conditions that occur in the event of fire. For each drill, the residential care agency must document the following information and retain it for a minimum of two years:

(A) Identity of the person conducting the drill.

(B) Date and time of the drill.

(C) Notification method used.

(D) Staff members on duty and participating.

(E) Number of children in care and staff evacuated.

(F) Special conditions simulated.

(G) Problems encountered.

(H) Time required to accomplish complete evacuation.

(b) The residential care agency must ensure that all employees and children in care are aware of the procedures to follow in case of emergencies.

(4) Hazards.

(a) The residential care agency must protect children in care from guns, drugs, plastic bags, sharps, paint, hazardous materials, bio hazardous materials, and other potentially harmful materials. A residential care agency must have a written policy that addresses potentially harmful materials that are in the building accessible to the children in care in the program or on the grounds of the program.

(b) The temperature of hot water used for hand washing, bathing, or showering must be controlled so that it does not exceed 120 degrees Fahrenheit in all buildings serving children in care. Direct supervision by staff must be provided for any child in care who does not have the ability to adjust and control water temperature.

(c) Each light fixture must have a protective cover unless it is designed to be used without one.

(5) Transportation. The residential care agency must ensure the following when providing transportation to children in care:

(a) Driver requirements.

(A) Each employee transporting a child in care in a motor vehicle must have a current driver license on record with the residential care agency.

(B) The residential care agency may use an employee to provide transportation for children in care only if the employee is covered by an insurance policy in full force and effect, and in compliance with the standards set by the residential care agency.

(C) The residential care agency must ensure that employees providing transportation are trained in emergency procedures, including behavior management, while in a vehicle.

(D) The residential care agency must ensure that each person who transports a child in care in a van for 15 or more passengers receives training in the safe operation of that type of vehicle prior to transporting children in care.

(b) Vehicle requirements.

(A) Each vehicle used to transport a child in care served by the residential care agency must be covered by an insurance policy in full force and effect.

(B) Each vehicle used to transport a child in care served by the residential care agency must be maintained in safe operating condition.

(C) Each vehicle used to transport a child in care must have aboard a first aid kit, a fully charged and working fire extinguisher with a rating of at least 2-A:10-BC, and a copy of the medical insurance card of each child in care being transported.

(D) Each vehicle used to transport a child in care must be smoke-free.

(E) Children in care and adults must ride in a vehicle manufactured seat, properly using the passenger restraint device in accordance with Oregon law when traveling on public roads.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0110, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0546
Health Services

(1) A residential care agency must obtain all private health record information referred to in this rule in a manner that complies with federal and state law.

(2) Medical history. Within 30 days of a child in care being placed with a residential care agency, the residential care agency must obtain available medical history and other health-related information on the child in care, including:

(a) Significant findings of the most current physical examination;

(b) The child in care's current immunizations, history of surgical procedures and significant health issues or injuries, and past or present communicable diseases;

(c) Any known allergies;

(d) Dental, vision, hearing, and behavioral health;

(e) Documentation that the child in care has received age-appropriate instruction regarding pregnancy prevention, nutrition, prevention of HIV and AIDS, and general information about the prevention and treatment of sexually transmitted disease; and

(f) Physician or qualified medical professional's orders, including those related to medications, if any.

(3) Health services. The foster care agency must provide or arrange for the following health services, as applicable:

(a) Information on maintaining reproductive health and birth control.

(b) Prenatal care.

(c) Well-baby care.

(d) Fetal alcohol syndrome.

(e) Accessing child and infant health insurance programs.

(f) Screening for breast and other common cancers.

(g) Provide all necessary feminine hygiene products.

(h) Access to birth control, vaccinations, and information about preventing sexually transmitted diseases.

(4) Medical examinations. A residential care agency must safeguard the health of each child in care it serves by providing for a medical examination by a physician or qualified medical professional at the following intervals:

(a) Three examinations during the first year of the child's life.

(b) One examination at the age of two.

(c) One examination at the age of four.

(d) One examination at the age of six.

(e) One examination at the age of nine.

(f) One examination at the age of 14.

(5) A residential care agency must have established protocols for accessing routine and urgent care for the children in care with the residential care agency.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0160, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0551
Medication

A residential care agency must meet all of the following requirements:

(1) Policy and procedures. The residential care agency must have policies and procedures that cover all prescription and non-prescription medications that address all of the following:

(a) How the medication will be administered.

(b) By whom the medication will be administered.

(c) How the staff of the residential care agency who administer medication will be trained.

(d) How the administration of medication will be documented.

(e) How the administration of medication will be monitored.

(f) How unused medication will be disposed of.

(g) The process that ensures that each child in care's prescription and non-prescription medications are reviewed, unless the medications are all provided through a single pharmacy. As used in this rule, "non prescription medication" means any medication that does not require a written prescription for purchase or dispensing and includes the use of any herbal remedies or supplements.

(2) A prescription, signed by a physician or qualified medical professional, is required before any prescription medication is administered to, or self-administered by a child in care. Medications prescribed for one child in care may not be administered to, or self-administered by another child in care or staff. As used in this rule, "self-administration of medication" refers to the act of a child in care placing a medication internally in, or externally on, his or her own body.

(3) A written approval, signed by a physician or qualified medical professional, is required for any use of herbal supplements or remedies.

(4) A written order, signed by a physician or qualified medical professional, is required for any medical treatment, special diet, physical therapy, aid to physical functioning, or limitation of activity.

(5) Before a residential care agency permits a child in care to self-administer prescription medication, self-administration must be recommended by the qualified medical professional, approved in writing by a physician or qualified medical professional, and closely monitored by the staff of the residential care agency.

(6) Medication storage.

(a) Prescription medications that are unused and medications that are outdated or recalled may not be maintained in the facility. "Outdated" means any medication whose designated period of potency, as indicated on the label, has expired.

(b) The facility may maintain a stock supply of non-prescription medications.

(c) All prescription and non-prescription medications stored in the facility must be kept in a manner that they are inaccessible to children in care.

(d) Medications requiring refrigeration must be refrigerated and secured.

(e) Medications must be maintained and stored in its original container, including the prescription label.

(7) Medication disposal. Medications must be disposed of in a manner that ensures that they cannot be retrieved, in accordance with all applicable state and federal law.

(8) A written record of all medication disposals must be maintained and must include all of the following:

(a) A description of the prescribed medication and the amount disposed.

(b) The child in care for whom the medication was prescribed.

(c) The reason for disposal.

(d) The method of disposal.

(e) The name of the adult disposing the medication, and the initials of an adult witness.

(9) Medication records. A written record must be kept for each child in care listing all medications, both prescription and over-the-counter, that are administered. The record must include all of the following:

(a) The name of the child in care.

(b) A description of the medication, instructions for use, and the recommended dosage.

(c) Dates and times medication is administered.

(d) A record of missed dosages.

(e) Medication dropped or disposed of.

(f) Method of administration for each medication.

(g) Identification of the person administering the medication.

(h) Any possible adverse reactions to the medication.

(i) Documentation of any medication taken outside the facility to be administered during a home visit or other activity.

(10) Where applicable, the residential care agency must maintain documentation of the continuing evaluation of the ability of the child in care to self-administer a medication.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0554
Extracurricular, Enrichment, Cultural, and Social Activities

The residential care agency must:

(1) Support the child in care in his or her interests to participate in age-appropriate or developmentally appropriate activities, including extracurricular, enrichment, cultural, and social activities.

(2) Ensure the child in care has ongoing opportunities to participate in at least one age-appropriate or developmentally appropriate activity.

(3) Apply the reasonable and prudent parent standard when determining whether to allow a child in care in substitute care to participate in extracurricular, enrichment, cultural, and social activities.

(4) Designate at least one on-site employee authorized to apply the reasonable and prudent parent standard to decisions involving participation in age-appropriate or developmentally appropriate activities with respect to any child in care at the residential care agency. When applying the reasonable and prudent parent standard, the designated employee must consider:

(a) The age, maturity, and developmental level of a child in care.

(b) The nature and inherent risks of harm.

(c) The best interest of the child in care based on information known by the designated employee.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0556
Staff Training

In addition to the orientation requirements in OAR 413-215-0061(4), a residential care agency must meet all of the following training requirements with respect to its staff:

(1) Staff of the residential care agency must be provided with orientation training prior to or within 30 days of hire. The orientation must include training on all of the following:

(a) Discipline and behavior management protocols including de-escalation skills training, crisis prevention skills, positive behavior management, and disciplinary techniques that are non-punitive in nature and are focused on helping children in care build positive personal relationships and self-control.

(b) If restraint and seclusion are utilized by the residential care agency, which techniques are approved by the residential care agency and how use of these procedures is monitored. The policy of the residential care agency must be clear in training that restraint or seclusion is used as an intervention of last resort.

(2) Staff of the residential care agency must receive ongoing training at least annually on all of the following:

(a) Procedures for handling environmental emergencies.

(b) Universal precautions (infection control guidelines designed to protect workers from exposure to diseases spread by blood and certain body fluids) and hygiene.

(c) Discipline and behavior management.

(3) Staff providing direct care of children in care of the residential care agency must receive training in cardiopulmonary resuscitation and first aid sufficient to retain a current certification.

(4) Designated staff authorized to apply the reasonable and prudent parent standard must receive training related to the application of the reasonable and prudent parent standard and age-appropriate or developmentally appropriate activities for a child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 33-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0561
Minimum Staffing Requirements

A residential care agency must meet all of the following requirements:

(1) Minimum staffing patterns. The residential care agency must establish staff-to-child ratios that will provide adequate supervision and protection for children in care. The ratios must be adequate for the type of program, location of program, the age and type of children in care served, physical plant design, location and ability of the supervisor to respond, electronic backup systems, and other means available to ensure a high standard of supervision and protection. The minimum staffing ratios are as follows:

(a) For children in care who are under 30 months of age — one direct care staff for each four children in care.

(b) For children in care who are 30 months of age or older and either less than six years of age or non-ambulatory, one direct care staff for each six children in care.

(c) For children in care who are six years of age or older, one direct care staff for each seven children in care.

(2) Overnight staffing requirements.

(a) A residential care agency must have policies and procedures regarding overnight supervision of children in care. The procedures must describe how staff must monitor and ensure the safety of children in care during sleeping hours. If the residential care agency houses more than one child in care to a bedroom or uses dormitory-type sleeping arrangements, the procedure must specifically address those living arrangements.

(b) During normal sleeping hours, the minimum staffing requirement is one awake direct care staff on duty in the facility for each 10 children in care.

(3) At least one staff member of each shift must have current certification in cardiopulmonary resuscitation and first aid.

(4) Additional staffing requirements for emergency response.

(a) When there is only one staff of the residential care agency on duty in the facility, there must be additional staff immediately available in the event of an emergency, with a maximum response time of 30 minutes. The names of additional staff who are available for immediate response must be listed on the schedule for each time period when only one staff person is on duty in the facility.

(b) One staff who is age 18 or over and capable of taking appropriate action in an emergency must be on site at all times when one or more residents are present on the residential facility premises.

(5) Staffing requirements for reasonable and prudent parent standard. There must be at least one on-site employee designated to apply the reasonable and prudent parent standard to decisions involving participation in age-appropriate or developmentally appropriate activities with respect to any child in care placed at the residential care agency.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0080, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0566
Separation of Residents

A residential care agency must meet all of the following requirements:

(1) Combining children and adults. Special care must be taken by a residential care agency to provide adequate supervision of children in care when adults are being served by the residential care agency. Children in care over 18 years must be housed in separate bedrooms from children in care under 18 years, except that a child in care and the children in care's parent may be housed in the same room if the children in care is the child's caretaker. If a children in care is 18 years of age or older, and is to share a bedroom with a children in care under 18 years of age, the residential care agency must obtain written approval from the Department licensing coordinator.

(2) Co-ed facilities. Special care must be taken by a residential care agency to provide adequate supervision when the program serves both males and females concurrently. Children's bedrooms for males must be separated from bedrooms for females.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0090, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0571
Referral and Initial Evaluation of Children

(1) Referral. A residential care agency must have a policy that addresses the process by which children in care are referred to the residential care agency. The policy must include all of the following:

(a) From whom referrals are accepted.

(b) On what basis children are accepted by the residential care agency.

(c) How information necessary to provide for the safety and care of children in care will be provided to the appropriate care staff

(2) Initial evaluation of a child. A residential care agency must evaluate each child in care referred to the residential care agency. In conducting the evaluation, the residential care agency must:

(a) Request and review all available reports of the child in care's past and present behavior, educational status, and physical and behavioral health.

(b) Make a preliminary determination whether the prospective child in care has disorders, disabilities, or deficits due to mental, emotional, behavioral, or physical problems for which care, supervision, training, rehabilitation, or treatment is needed to reduce a problem, maintain present level of functioning, or clarify the ongoing placement or service needs of the child in care.

(3) A residential care agency must be prepared to provide to a parent or legal guardian of a referred child in care suggestions for obtaining resources in the event the child in care is not accepted by the residential care agency.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-210-0170, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0576
Consents, Disclosures, and Authorizations

(1) Consents. For each child in care in placement with a residential care agency, the residential care agency must ensure that a parent or legal guardian signs a consent that authorizes the residential care agency to undertake each of the following:

(a) To provide routine and emergency medical care. However, if the parent or legal guardian relies on prayer or spiritual means for healing in accordance with the creed or tenets of a well-recognized religion or denomination, the residential care agency is not required to use medical, psychological or rehabilitative procedures, unless the child in care is old enough to consent to these procedures and does so. The residential care agency must have policies and procedures for this practice, which are reviewed and approved by the child in care's parent or legal guardian.

(b) To use the discipline and behavior management system of the residential care agency.

(c) To use restraint or seclusion in the management of the child in care. The consent must specify the reasons such interventions are used by the residential care agency and how the employees of the residential care agency are trained and supervised in the use of restraint or seclusion.

(d) To restrict the child's contact with persons outside the residential care agency, including visits, telephone communication, electronic mail, and postal mail, except that access to a child in care must be allowed as provided in ORS 418.305 and OAR 413-215-0091(11).

(e) To impose a dress code.

(f) To apply the reasonable and prudent parent standard to determine whether the child in care is allowed to participate in age-appropriate or developmentally appropriate activities including extracurricular, enrichment, cultural, and social activities.

(2) Disclosures to parent or legal guardian. At the time a residential care agency takes a child in care into placement, the residential care agency must ensure that each parent or legal guardian of the child in care receives and acknowledges in writing the receipt of each of the following:

(a) Information regarding any personal or room searches and protocols for confiscation of contraband items, including the notification of law enforcement if illegal contraband is discovered. This information will include the procedures and rationales of the residential care agency for any program-initiated room or body search.

(b) A statement concerning the rights of children in care and parents or legal guardians served by the residential care agency as provided in OAR 413-215-0046. The statement must be written in a manner that is easy to understand, and the residential care agency must ensure that the child and the parent or legal guardian understand the statement.

(c) The residential care agency will make any written policy or procedure pertaining to program services available for review by the child in care, parent, or legal guardian, upon request.

(3) Authorizations.

(a) Written authorizations to exchange information with others must be filled out prior to signatures being requested.

(b) All child-specific visitors must be approved or authorized by the parent or legal guardian, except CASAs and attorneys appointed to represent the child in care.

(c) Visitation resources must be pre-approved by the child's parent or legal guardian and the identity of these resources verified by the residential care agency in care.

(d) Activity-specific authorizations must be pre-approved by the child in care's parent or legal guardian to allow children to participate in potentially hazardous activities, such as using motorized yard equipment, swimming, and horseback riding.

(e) All other required authorizations must be pre-approved by the child in care's parent or legal guardian.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 33-2008, f. & cert. ef. 10-17-08; CWP 19-2015, f. & cert. ef. 10-1-15; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0581
Information About Children in Care

(1) Case files of children in care. For each child in care a residential care agency accepts for placement, the residential care agency must maintain an individual record that includes a summary sheet containing all of the following information:

(a) The name, gender, date of birth, religious preference, and previous address of the child in care.

(b) The name and location of the child in care's previous school.

(c) The date of admission to the program.

(d) The status of the child in care's legal custody, including the name of each person responsible for consents and authorizations.

(e) The name, address, and telephone number of:

(A) The child in care's parents.

(B) The child in care's legal guardian, if different than parents, and documentation of his or her legal relationship to the child in care.

(C) Other family members or other persons identified by the family as significant to the child in care.

(D) Other professionals to be involved in service planning, if applicable.

(2) Service planning.

(a) All documentation, including but not limited to service plans, daily notes, assessments, progress reports, medication records, and incident reports, must be written in terms that are easily understood by all persons involved in service planning.

(b) Intake documentation. A residential care agency must complete a written intake document containing screening information on the date the residential care agency accepts a child in care for placement except in the case of an emergency placement, when the intake document must be completed within 48 hours of admission.

(c) Each child in care must be served according to an individual written service plan developed by staff of the residential care agency and by, whenever possible, the child in care, the child's family, and other profes-

sionals involved with the child in care or family. This document must outline goals for services and care coordination.

(d) Assessment. A comprehensive assessment must be completed within the first 30 days of placement. This assessment must include relevant historical information, current behavioral observations, any identified needs for services, and a description of how the residential care agency will provide or coordinate services.

(e) Service plan and review.

(A) Within 60 days of placement, a formal service plan must be developed by staff of the residential care agency in conjunction with the child in care and his or her parents or legal guardians, and any other persons who are actively involved with the family, as appropriate.

(B) The service plan must reflect how the residential care agency will address the child in care's issues, describe the anticipated outcomes of the placement, and be reviewed and approved by the child in care and the legal guardian or parent, unless contraindicated.

(C) The service plan must be reviewed by the residential care agency at least quarterly.

(D) Service plans must be revised at any time additional information becomes available indicating that other services should be provided.

(3) Case management.

(a) The residential care agency must document services provided, and track and monitor progress toward the achievement of service plan goals.

(b) Discharge. The residential care agency must identify how a child in care's progress will be evaluated, and how the determination is made of readiness for discharge or unsuitability for continued stay.

(c) Discharge planning. Discharge planning for children in care must be a participatory decision-making process between the child in care, staff of the residential care agency, the parents or legal guardian, and significant others. As used in this rule, "significant others" mean relatives, friends, or interested members of the community.

(d) Discharge instructions. The residential care agency must provide the child in care and the child in care's guardian with discharge instructions on or before the discharge date, including current medications, name of the physician or qualified medical professional who prescribed each medication, any outstanding medical or other appointments, and other follow-up instructions as needed.

(e) Follow-up services. The residential care agency must identify any transitional or aftercare services or service coordination that will be offered by the program.

(f) Incident reporting. A written description of any injury, accident, or unusual incident involving a child in care must be placed in the individual child's record.

(4) Financial records. A residential care agency must keep a separate written record for each child itemizing all money received or disbursed on behalf of the child in care. The record must include all of the following:

(a) The date of each receipt and disbursement and the amount of each.

(b) The source of income.

(c) The purpose of each disbursement.

(d) The signature of the person making each entry.

(e) The signature of the child in care for each entry.

(5) Personal possessions records. An individual written inventory must be maintained for each child in care of all personal possessions belonging to the child in care. The record must be updated as needed.

(6) The residential care agency will ensure, in policy and practice, that:

(a) Disallowable items are either stored, or returned to the parent or legal guardian; and

(b) All money and personal belongings are returned to the child in care at the time of discharge.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 106
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Renumbered from 413-120-0180, CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0586
Notification to Public Schools

(1) This rule applies if a residential care agency intends any of the actions:

(a) To establish or expand a residential program for children.

(b) To change the type of educational services provided.

(c) To change the population of children to be served by an existing program.

(2) Prior to an action covered by section (1) of this rule, a residential care agency must notify the superintendent or school board of the local school district, in writing, three months prior to making the intended change in order for the school district to make a determination of the effect of different, or additional, services upon the facilities and programs of the district.

(3) A residential care agency must send written proof of compliance with ORS 336.575 to the Department licensing coordinator.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 336.575, 418.205 - 418.327, OL 2016, ch 106
Hist.: CWP 33-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0601
Therapeutic Boarding Schools; What Law Applies

These rules, OAR 413-215-0601 to 413-215-0681 regulate a child-caring agency licensed as a therapeutic boarding school. A therapeutic boarding school must also comply with OAR 413-215-0001 to 413-215-0131.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0606
Definitions

The following definitions apply to OAR 413-215-0601 to 413-215-0681:

(1) "Boarding" means *care* or treatment services provided on a 24 hour per day basis to children.

(2) "Care" means services provided to meet the needs of a child, such as food, shelter, clothing, medical care, schooling, protection, and supervision.

(3) "Child" means an individual under 18 years of age.

(4) "Employee" means an individual holding a paid position with a therapeutic boarding school.

(5) "Facility" means the physical setting, property, structures, or equipment of a *therapeutic boarding school*.

(6) "Family" means related members of a household, among whom at least one adult functions as a parent to one or more minor children.

(7) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance either internally or externally by any person.

(8) "Staff" means employees of the therapeutic boarding school who are responsible for providing direct care or treatment to students.

(9) "Student" means a residential client of a therapeutic boarding school.

(10) "Therapeutic boarding school" means an organization or a program in an organization that:

(a) Is primarily a school and not a residential care agency (defined in OAR 413-215-0506);

(b) Provides educational services and care to children for 24 hours a day; and

(c) Holds itself out as serving children with emotional or behavioral problems, providing therapeutic services, or assuring that children receive therapeutic services.

Stat. Auth.: ORS 409.050, 418.005, 418.327
Stats. Implemented: ORS 409.010, 418.005, 418.327
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0611
Educational Services

The educational services of a therapeutic boarding school must comply with all of the following requirements:

(1) The therapeutic boarding school must comply with the minimum requirements for private education institutions as determined by the Oregon Department of Education.

(2) Education services must include at least one qualified teacher for every fifteen children in care.

(3) The therapeutic boarding school must ensure that it has a curriculum that considers the goals of modern education as defined in OAR 581-022-1020 and the requirements of a sound, comprehensive curriculum.

(4) Secondary schools must verify that they have academic standards necessary for children in care to obtain admission to community colleges and institutions of higher education and receive a high school diploma or GED.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0616
Physical Plant Requirements

A therapeutic boarding school must meet all of the following requirements:

(1) All buildings owned, maintained, or operated by the therapeutic boarding school to provide services to children in care must meet all applicable state and local building, electrical, plumbing, and zoning codes.

(2) All areas of any buildings where children in care receive services must be kept clean and in good repair. Major Appliances and heating, ventilation, plumbing and electrical systems must be functional and in good repair.

(3) Each room used by children in care must have floors, walls, and ceilings that meet the interior finish requirements of the applicable Oregon Structural Specialty Code (see the current version of OAR 837-040-0140) and the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020) and be free of harmful drafts, odors, and excessive noise.

(4) Each room used by children in care must be adequate in size and arrangement for the purpose in which it is used.

(5) A system providing a continuous supply of hot and cold water must be distributed to taps conveniently located throughout each facility.

(6) Water systems serving the property must be installed and maintained in compliance with applicable drinking water regulations (see OAR chapter 333) from the Public Health Division of the Oregon Health Authority.

(7) Heat and ventilation.

(a) Buildings must be ventilated by natural or mechanical means and must be free of excessive heat, condensation, and obnoxious odors.

(b) Room temperature must be maintained within a normal comfort range.

(8) Individual rooms.

(a) Living area. A separate living room or lounge area must be available for the exclusive use of children in care, employees, and invited guests.

(b) Bedrooms. Bedrooms for children in care may not be exposed to drafts, odors, or noises that interfere with the health or safety of the occupants. Each bedroom must comply with all of the following requirements:

(A) Be separate from the rooms used for dining, living, multi-purpose, laundry, kitchen, or storage.

(B) Be an outside room, with a window of at least the minimum size required by the State Fire Marshal and building codes;

(C) Have a ceiling height of at least 90 inches.

(D) Have a minimum of 60 square feet per bed.

(E) House no more than 25 children in care in one room when a dormitory-style sleeping arrangement is used.

(F) Have permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(G) Have a window covering on each window to ensure privacy.

(H) Contain beds for children in care that meet both of the following requirements:

(i) There must be at least three feet between beds, including trundle beds if used; and

(ii) Bunk beds, if used, must be maintained to ensure safety of the children in care.

(c) Restrooms must be provided and be conveniently located, and must have:

(A) A minimum of one toilet for every eight children in care.

(B) One hand-washing sink with mixing faucets for each toilet. The sink may not be used for the preparation of food or drinks or for dish washing.

(C) Hot and cold running water, soap, and paper towels at each hand washing sink or other hand drying options approved by an environmental health specialist.

(D) Arrangements for individual privacy for users.

(E) Permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(F) A window covering on each window to ensure privacy.

(G) Adequate ventilation.

(H) Each self-closing metered faucet, if provided, must provide water flow for at least 15 seconds without the need to reactivate the faucet.

(d) Laundry facilities must be separate from:

(A) Kitchen and dining areas;

(B) Living areas, including bedrooms for children in care; and

(C) Areas used for the storage of un-refrigerated perishable food.

(e) Storage areas must be provided appropriate to the size of the facility. Separate storage areas must be provided for:

(A) Food, kitchen supplies, and utensils.

(B) Clean linens.

(C) Soiled linens and clothing.

(D) Cleaning compounds equipment.

(E) Poisons, chemicals, pest control products, insecticides, and other toxic materials, which must be properly labeled, stored in the original container, and kept in a locked storage area.

(F) Outdoor recreational and maintenance equipment.

(f) Food service areas.

(A) Kitchens must have facilities for dish washing, storage, and preparation of food.

(B) The walls, floors, and floor coverings of all rooms in which food or drink is prepared or stored or in which utensils are washed or stored must be smooth, washable, and easily cleanable.

(C) All equipment and utensils used for food service, including plastic ware and food-contact surfaces, must be easily cleanable, durable, nontoxic, and non-absorbent and must be maintained in a clean and sanitary condition.

(D) All equipment used for food preparation must be installed and maintained in a manner providing ease of cleaning beneath, around, and behind each unit.

(g) Dining area. A separate dining room or area must be provided for the exclusive use of children in care, employees, and invited guests. The dining area must have the capacity to seat at least one-half of the children in care at one time and must contain a minimum of 15 square feet per child in care.

(h) Classrooms and school buildings must be adequate in size and arrangement for the programs offered.

(i) Time-out rooms. Rooms used for time out or quiet time must have adequate space, heat, light, and ventilation and must not be capable of locking.

(j) Activity area. A usable recreational activity area must be provided that is:

(A) Protected from motor traffic and other hazards; and

(B) Of a size and availability appropriate to the age and the needs of the children in care served by the therapeutic boarding school.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0621
Student Furnishings and Personal Items

A therapeutic boarding school must meet all of the following requirements:

(1) Furniture. Adequate furnishings must be provided for each child in care including, but not limited to:

(a) A bed, including a frame;

(b) A clean, comfortable mattress; and a pillow; and

(c) A private dresser, closet, or similar storage area for personal belongings that is readily accessible to the child in care.

(2) Linens. Linens in good repair must be provided or arranged for each child in care, including:

(a) A waterproof mattress cover or waterproof mattress;

(b) Sheets and pillowcase;

(c) Blankets appropriate in number and type for the season and the comfort of the individual child in care; and

(d) Towels and washcloths.

(3) Bedding must be changed when soiled and upon change of occupant.

(4) Personal hygiene supplies. Individual personal hygiene supplies that are appropriate to the child in care's age, gender, and culture must be provided or arranged for each child in care, and must include:

(a) A comb;

(b) Shampoo, or other hair cleansing product;

(c) A toothbrush;

(d) Soap;

(e) Deodorant;

(f) Toothpaste;

(g) Toilet paper;

(h) Menstrual supplies, if appropriate; and

(i) Other supplies that are appropriate to the age, gender, and cultural needs of the child in care.

(5) Clothing. Adequate and seasonally appropriate clothing must be provided or arranged for each child in care for the exclusive use of the child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106

Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0626
New Facility or Remodel

A therapeutic boarding school must meet all of the following requirements:

(1) A set of plans and specifications for each boarding facility operated by the therapeutic boarding school must be submitted to the Department and to the State Fire Marshal for approval;

(a) Prior to construction of a new building;

(b) Prior to construction of an addition to an existing building;

(c) Prior to the remodeling, modification, or conversion of a building; and

(d) In support of an application for initial license of a therapeutic boarding school under OAR 413-215-0001 to 413-215-0131 and OAR 413-215-0601 to 413-215-0681.

(2) The required plans must comply with both current Oregon Structural Specialty Codes (see OAR 837-040-0140) and local fire and safety codes.

(3) Plans must be drawn to scale and must specify the estimated date upon which construction, modification, or conversion will be completed.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0631
Environmental Health

A therapeutic boarding school must meet all of the following requirements:

(1) The program of the therapeutic boarding school must maintain an environment that ensures safety for program staff and children in care.

(2) Environmental Health Specialist approval. Prior to licensure and every two years upon license renewal, the program must be assessed and provide documentation of approval by a registered environmental health specialist (see OAR 338-010-0025 to 338-010-0038) for the following safety areas:

(a) Food service risk assessment.

(b) Drinking water or waste water assessment.

(c) Vector and pest control, including the use of pesticides and other chemical agents.

(d) Hazardous material management, including handling and storage.

(e) Recreation assessments (such as playgrounds, swimming pools, and hot tubs) for injury prevention and hazard mitigation.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0636
Food Services

A therapeutic boarding school must meet all of the following requirements related to food services:

(1) Nutrition and dietary requirements.

(a) A therapeutic boarding school must arrange meals daily, consistent with normal mealtimes.

(b) Snacks must be available and provided as appropriate to the age and activity levels of children in care.

(c) Menus must be prepared in advance in accordance with USDA guidelines and must provide a sufficient variety of foods served in adequate amounts for each student at each meal, adjusted for seasonal changes. Records of menus as served must be maintained in the therapeutic boarding school record for at least six months.

(d) Drinking water must be freely available to the children in care served by the therapeutic boarding school.

(2) Food selection, storage, and preparation.

(a) All food and drink provided by the therapeutic boarding school must be stored, prepared, and served in a sanitary manner.

(b) All employees who handle food served to children in care must have a valid food handler's card pursuant to ORS 624.570.

(c) Selection of food. All food products served by a therapeutic boarding school must be obtained from commercial suppliers, except that:

(A) Fresh fruits and vegetables and fruits or vegetables frozen by the therapeutic boarding school may be served.

(B) The serving of unpasteurized juice is prohibited.

(d) Requirements related to milk.

(A) Only Grade A pasteurized and fortified milk may be served to children in care.

(B) Milk and fluid milk products must be dispensed from a commercially filled plastic container of not more than one-gallon capacity or from a refrigerated bulk container equipped with a dispensing device approved by the Food and Drug Administration or the Oregon Department of Agriculture.

(e) Children in care may participate in activities in a food-preparation area, other than routine clean up, only while under the supervision of the employees of the therapeutic boarding school.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0641
Safety

A therapeutic boarding school must meet all of the following requirements related to safety:

(1) Fire safety. Prior to licensure and every two years upon license renewal, the program must be assessed and approved by the State Fire Marshall or designee for the following fire safety areas:

(a) The therapeutic boarding school must provide fire safety equipment that meets the requirements of applicable building codes and the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020).

(b) The therapeutic boarding school must comply with existing state and local fire safety codes.

(2) Emergency plan.

(a) The therapeutic boarding school must have, for each facility it operates, a written emergency plan that includes:

(A) Instructions for evacuation of children in care and employees in the event of fire, explosion, accident, or other emergency.

(B) Instructions for response in the event of a natural disaster, external safety threat, or other emergency.

(b) Telephone numbers for local police and fire departments and other appropriate emergency numbers must be posted near all telephones.

(c) Operative flashlights sufficient in number must be readily available to the staff in case of emergency.

(3) Evacuation drills.

(a) An unannounced evacuation drill must be held monthly under varying conditions to simulate the unusual conditions that occur in the event of fire. For each drill, the therapeutic boarding school must document the following information and retain it for a minimum of two years:

(A) Identity of the person conducting the drill.

(B) Date and time of the drill.

(C) Notification method used.

(D) Staff members on duty and participating.

(E) Number of children in care and staff evacuated.

(F) Special conditions simulated.

(G) Problems encountered.

(H) Time required to accomplish complete evacuation.

(b) The therapeutic boarding school must ensure that all employees and children in care are aware of the procedures to follow in case of emergencies.

(4) Hazards.

(a) The therapeutic boarding school must protect children in care it serves from guns, drugs, plastics bags, sharps, paint, hazardous materials, bio-hazardous materials, and other potentially harmful materials. A therapeutic boarding school must have a written policy that addresses potentially harmful materials that are in the building accessible to the children in care in the program or on the grounds of the program.

(b) The temperature of hot water used for hand washing, bathing, or showering must be controlled so that it does not exceed 120 degrees Fahrenheit in all buildings serving children in care. Direct supervision by staff must be provided for any child in care who does not have the ability to adjust and control water temperature.

(c) Each light fixture must have a protective cover unless it is designed to be used without one.

(5) Transportation. The therapeutic boarding school must ensure the following when providing transportation to children in care:

(a) Driver requirements.

(A) Each employee transporting a child in care in a motor vehicle must have a current driver license on record with the therapeutic boarding school.

(B) The therapeutic boarding school may use an employee to provide transportation for children in care only if the employee is covered by an insurance policy in full force and effect, and in compliance with the standards set by the therapeutic boarding school.

(C) The therapeutic boarding school must ensure that employees providing transportation are trained in emergency procedures, including behavior management, while in a vehicle.

(D) The therapeutic boarding school must ensure that each person who transports a child in care in a van for 15 or more passengers receives training in the safe operation of that type of vehicle prior to transporting students.

(E) Children in care and adults must ride in a vehicle manufactured seat, properly using the passenger restraint device in accordance with Oregon law when traveling on public roads.

(b) Vehicle requirements.

(A) Each vehicle used to transport a child in care served by the therapeutic boarding school must be covered by an insurance policy in full force and effect.

(B) Each vehicle used to transport a child in care served by the therapeutic boarding school must be maintained in safe operating condition.

(C) Each vehicle used to transport a child in care must have aboard a first aid kit, a fully charged and working fire extinguisher with a rating of at least 2-A:10-BC, and a copy of the medical insurance card of each student being transported.

(D) Each vehicle used to transport a child in care must be smoke-free.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 106
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 106
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0646
Health Services

(1) A therapeutic boarding school must obtain all personal health record information referred to in this rule in a manner that complies with federal and state law.

(2) Medical history. Within 30 days of a child in care starting with a therapeutic boarding school, the therapeutic boarding school must obtain available medical history and other health-related information on the student, including:

(a) Significant findings of the most current physical examination;

(b) The child in care's current immunizations, history of surgical procedures and significant health issues or injuries, and past or present communicable diseases, within ORS 192.518 to 192.526;

(c) Any known allergies;

(d) Dental, vision, hearing, and behavioral health; and

(e) Physician or qualified medical professional's orders, including those related to medication, if any.

(3) A therapeutic boarding school must have established protocols for accessing routine and urgent care for the children in care with the therapeutic boarding school.

(4) Health services. The therapeutic boarding school must provide or arrange for the following health services, as applicable:

(a) Information on maintaining reproductive health and birth control.

(b) Prenatal care.

(c) Well-baby care.

(d) Fetal alcohol syndrome.

(e) Accessing child and infant health insurance programs.

(f) Screening for breast and other common cancers.

(g) Provide all necessary feminine hygiene products.

(h) Access to birth control, vaccinations and information about preventing sexually transmitted diseases.

(5) A therapeutic boarding school must follow through with medical treatment requirements, adhere to treatment regimens related to a medical condition, and follow-up appointments and must provide transportation and access to health care providers for each child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 10
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0651
Medication

A therapeutic boarding school must meet all of the following requirements:

(1) Policy and procedures. The therapeutic boarding school must have policies and procedures that cover all prescription and non-prescription medication that address all of the following:

(a) How the medication will be administered.

(b) By whom the medication will be administered.

(c) How the staff of the therapeutic boarding school who administer medication will be trained.

(d) How the administration of medication will be documented.

(e) How the administration of medication will be monitored.

(f) How unused medication will be disposed of.

(g) The process that ensures that the prescription and non-prescription medications of each child in care is reviewed, unless the medications are all provided through a single pharmacy. As used in this rule, "non prescription medication" means any medication that does not require a written prescription for purchase or dispensing and includes the use of any herbal remedies or supplements.

(2) A prescription, signed by a physician or qualified medical professional, is required before any prescription medication is administered to, or self-administered by a child in care. Medication prescribed for one child in care may not be administered to, or self-administered by another child in care or staff. As used in this rule, "self administration of medication" refers to the act of a child in care placing a medication internally in, or externally on, his or her own body.

(3) A written approval, signed by a physician or qualified medical professional, is required for any use of herbal supplements or remedies.

(4) A written order, signed by a physician or qualified medical professional, is required for any medical treatment, special diet, physical therapy, aid to physical functioning, or limitation of activity.

(5) Medication storage.

(a) A prescription medication that is unused and any medication that is outdated or recalled may not be maintained in a facility. "Outdated" means any medication whose designated period of potency, as indicated on the label, has expired.

(b) The facility may maintain a stock supply of non-prescription medications.

(c) All prescription and non-prescription medications stored in the facility must be kept in locked storage and in a manner that makes them inaccessible to child in care.

(d) A medication requiring refrigeration must be refrigerated and secured.

(e) Each medication must be maintained and stored in its original container, including the prescription label.

(6) Medication disposal. Medication must be disposed of in a manner that ensures that it cannot be retrieved, in accordance with all applicable state and federal law.

(7) A written record of all medication disposals must be maintained and must include all of the following:

(a) A description of the prescribed medication and the amount disposed.

(b) The child in care for whom the medication was prescribed.

(c) The reason for disposal.

(d) The method of disposal.

(e) The name of the adult disposing the medication, and the initials of an adult witness.

(8) Medication records. A written record must be kept for each child in care listing each medication, both prescription and over-the-counter, that is administered. The record must include all of the following:

(a) The name of the child in care.

(b) A description of the medication, instructions for use, and the recommended dosage.

(c) Dates and times medication is administered.

(d) A record of missed dosages.

(e) Medication dropped or disposed of.

(f) Method of administration for each medication.

(g) Identification of the person administering the medication.

(h) Any adverse reactions to the medication.

(i) Documentation of any medication taken outside the facility to be administered during a home visit or other activity.

(9) Where applicable, the therapeutic boarding school must maintain documentation of the continuing evaluation of the ability of the child in care to self-administer a medication.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 10
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0656
Staff Training

In addition to the orientation requirements in OAR 413-215-0061(4), a therapeutic boarding school must meet all of the following training requirements with respect to its staff:

(1) Staff of the therapeutic boarding school must be provided with orientation training prior to or within 30 days of hire. The orientation must include training on all of the following:

(a) Discipline and behavior management protocols including de-escalation skills training, crisis prevention skills, positive behavior management, and disciplinary techniques that are non-punitive in nature and are focused on helping children in care build positive personal relationships and self-control.

(b) If restraint and seclusion are utilized by the therapeutic boarding school, approved techniques and monitoring. The training must be clear that the policy of the therapeutic boarding school is that restraint or seclusion is used as an intervention of last resort.

(2) Staff of the therapeutic boarding school must receive ongoing training on all of the following:

(a) Procedures for handling environmental emergencies.

(b) Universal precautions (infection control guidelines designed to protect workers from exposure to diseases spread by blood and certain body fluids) and hygiene.

(c) Behavior management.

(3) At all times, at least one of the staff of the therapeutic boarding school working with children in care must have received training in cardiopulmonary resuscitation and first aid sufficient to retain a current certification.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 10
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0661
Minimum Staffing Requirements

A therapeutic boarding school must meet all of the following requirements:

(1) Minimum staffing patterns. The therapeutic boarding school must establish ratios of staff to children in care that will provide adequate supervision, safety and protection for children in care. The ratios must be adequate to protect child safety and wellbeing for the type of program, location of program, the age and type of children in care served, physical plant design, location and ability of the supervisor to respond, electronic backup systems, and other means available to ensure a high standard of supervision and protection. The minimum staffing ratios outside normal sleeping hours are one direct care staff for each 10 children in care.

(2) Overnight staffing requirements.

(a) A therapeutic boarding school must have policies and procedures regarding overnight supervision of children in care. The procedures must describe how staff must monitor and ensure the safety of children in care during sleeping hours. If the therapeutic boarding school houses more than one child in care to a bedroom or uses dormitory-type sleeping arrangements, the procedure must specifically address those living arrangements.

(b) During normal sleeping hours, the minimum staffing requirement is one awake direct care staff on duty in the facility for each 14 children in care.

(3) Additional staffing requirements for emergency response.

(a) When there is only one employee of the therapeutic boarding school on duty in a facility, there must be additional staff immediately available in the event of an emergency, with a maximum response time of 30 minutes. The names of additional staff who are available for immediate response must be listed on the schedule for each time period when only one staff person is on duty in a facility.

(b) One employee who is age 18 or over and capable of taking appropriate action in an emergency must be on site at all times when one or more child in care is present on the residential facility premises.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 10
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0666
Separation of Children in Care

A therapeutic boarding school must meet all of the following requirements:

(1) Combining children and adults. Special care must be taken by a therapeutic boarding school to provide adequate supervision of children in care when adults are being served by the therapeutic boarding school. Children in care over and under 18 years of age must be housed in separate bedrooms, except that a child in care who is a parent may be housed in the same room if the child in care is the minor child's caretaker. If a child in care is 18 years of age or older, and is to share a bedroom with a child in care under 18 years of age, the therapeutic boarding school must obtain written approval from the Department licensing coordinator.

(2) Co-ed facilities. Special care must be taken by a therapeutic boarding school to provide adequate supervision when the program serves both males and females concurrently. Bedrooms for children in care for males must be separated from bedrooms for children in care for females.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 10
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0671
Referral and Initial Evaluation of Children in Care

(1) Referral. A therapeutic boarding school must have and follow a policy that addresses the process by which children in care are referred to the therapeutic boarding school. The policy must include all of the following:

(a) From whom referrals are accepted.

(b) On what basis children in care are accepted by the therapeutic boarding school.

(c) How information necessary to provide for the safety and care of children in care will be provided to the appropriate care staff.

(2) Initial evaluation of a student. A therapeutic boarding school must evaluate each prospective child in care referred to the therapeutic boarding school. In conducting the evaluation, the therapeutic boarding school must:

(a) Request and review all available reports of the child in care's past and present behavior, educational status, and physical and mental health.

(b) Make a preliminary determination whether the prospective child in care has disorders, disabilities, or deficits due to mental, emotional, behavioral, or physical problems for which care, supervision, training, rehabilitation, or treatment is needed to reduce a problem, maintain present level of functioning, or clarify the ongoing placement or service needs of the child in care.

(c) Arrange for ongoing therapeutic services appropriate for the child in care's specific needs and provide regular reports to the parents or legal guardians regarding the child in care's progress.

(3) A therapeutic boarding school must be prepared to provide to a parent or legal guardian of a referred student suggestions for obtaining resources in the event the child in care is not accepted by the therapeutic boarding school.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 10
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0676
Consents, Disclosures, and Authorizations

(1) Consents. For each child in care in placement with a therapeutic boarding school, the therapeutic boarding school must ensure that a parent or legal guardian signs a consent that authorizes the therapeutic boarding school, if applicable, to undertake each of the following:

(a) To provide routine and emergency medical care. However, if the parent or legal guardian relies on prayer or spiritual means for healing in accordance with the creed or tenets of a well-recognized religion or denomination, the therapeutic boarding school is not required to use medical, psychological, or rehabilitative procedures, unless the child in care is old enough to consent to these procedures and does so. The therapeutic boarding school must have policies and procedures for this practice, which are reviewed and approved by the child in care's parent or legal guardian.

(b) To use the discipline and behavior management system of the therapeutic boarding school.

(c) To use restraint or seclusion in the management of the child in care. The consent must specify the reasons such interventions are used by the therapeutic boarding school and how the employees of the therapeutic boarding school are trained and supervised in the use of restraint or seclusion.

(d) To restrict the student's contact with persons outside the therapeutic boarding school, including visits, telephone communication, electronic mail, and postal mail, except that access to a child in care must be allowed as provided in ORS 418.305 and OAR 413-215-0091(11).

(e) To impose a dress code.

(f) To restrict the child in care's participation in recreational or leisure activities in an appropriate manner, consistent with behavior or safety issues.

(2) Disclosures to parent or legal guardian. At the time a therapeutic boarding school takes a child in care into placement, the therapeutic boarding school must ensure that each parent or legal guardian of the child in care receives and acknowledges in writing the receipt of each of the following:

(a) Information regarding any personal or room searches and protocols for confiscation of contraband items, including the notification of law enforcement if illegal contraband is discovered. This information will include the procedures and rationales of the therapeutic boarding school for any program-initiated room or body search.

(b) A statement concerning the rights of children in care and parents or legal guardians served by the therapeutic boarding school as provided in OAR 413-215-0046. The statement must be written in a manner that is easy to understand, and the therapeutic boarding school must ensure that the child in care and the parent or legal guardian understand the statement.

(c) The grievance policies and procedures of the therapeutic boarding school.

(d) The therapeutic boarding school will make any written policy or procedure pertaining to program services available for review by the child in care, parent, or legal guardian, upon request.

(3) Authorizations.

(a) Authorization to disclose information from other service providers must be filled out prior to signatures being requested and be specific to one other provider. Information may only be requested on a need to know basis.

(b) All visitors for the child in care must be approved or authorized by a parent or legal guardian.

(c) Visitation resources must be pre-approved by the child in care's parent or legal guardian and the identity of these resources verified by the agency.

(d) Activity-specific authorizations must be pre-approved by the child in care's parent or legal guardian to allow children in care to participate in potentially hazardous activities, such as using motorized yard equipment, swimming, and horseback riding.

(e) All other required authorizations must be pre-approved by the child in care's parent or legal guardian.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 10
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0681
Information about Children in Care with the Therapeutic Boarding School

(1) Case files of children in care. For each child in care a therapeutic boarding school accepts for placement, the therapeutic boarding school must maintain an individual record that includes a summary sheet containing all of the following information:

(a) The name, gender, date of birth, religious preference, and previous address of the child in care.

(b) The name and location of the child in care's previous school.

(c) The date of admission to the program.

(d) The status of the child in care's legal custody, including the name of each person responsible for consents and authorizations.

(e) The name, address, and telephone number of:

(A) The child in care's parents.

(B) The child in care's legal guardian, if different than parents, and his or her legal relationship to the child in care.

(C) Other family members or other persons identified by the family as significant to the child in care.

(D) Other professionals to be involved in service planning, if applicable.

(2) Service planning.

(a) All documentation, including but not limited to service plans, daily notes, assessments, progress reports, medication records, and incident reports, must be written in terms that are easily understood by all persons involved in service planning.

(b) Intake documentation. A therapeutic boarding school must complete a written intake document containing screening information on the date the therapeutic boarding school accepts a child in care, except in the case of an emergency placement when the intake document must be completed within 48 hours of admission.

(c) Each child in care must be served according to an individual written service plan developed by staff of the therapeutic boarding school and including, whenever possible, the child in care, the child in care's family, and other professionals involved with the child in care or family. This document must outline goals for services and care coordination.

(d) Assessment. A comprehensive assessment must be completed within the first 30 days of placement. This assessment must include relevant historical information, current behavioral observations, any identified needs for services, and a description of how the therapeutic boarding school will provide or coordinate services.

(e) Service plan and review.

(A) Within 60 days of placement, a formal service plan that meets the identified needs of the child in care must be developed by staff of the therapeutic boarding school in conjunction with the child in care and his or her parents or legal guardians, and any other persons who are actively involved with the family, as appropriate.

(B) The service plan must reflect how the therapeutic boarding school will address the child in care's issues, describe the anticipated outcomes of the placement, and be reviewed and approved by the child in care and the legal guardian or parent, unless contraindicated.

(C) The service plan must be reviewed by the therapeutic boarding school at least quarterly.

(D) Service plans must be revised at any time additional information becomes available indicating that other services should be provided.

(3) Case management.

(a) The therapeutic boarding school must document services provided, as necessary, to track and monitor progress toward the achievement of service plan goals.

(b) Discharge. The therapeutic boarding school must identify how a child in care's progress will be evaluated, and how the determination is made of readiness for discharge or unsuitability for continued stay.

(c) Discharge planning. Discharge planning for children in care must be a participatory decision-making process between the child in care, therapeutic boarding school staff, the parent or legal guardian, and significant others. As used in this rule, "significant others" mean relatives, friends, or interested members of the community.

(d) Discharge instructions. The therapeutic boarding school must provide the child in care and the child in care's guardian with discharge instructions on or before the discharge date, including current medications, name of the doctor who prescribed each medication, any outstanding medical or other appointments, and other follow-up instructions as needed. The therapeutic boarding school must obtain a forwarding address for any discharge instructions received by the therapeutic boarding school after discharge of the child in care.

(e) Follow-up services. The therapeutic boarding school must identify any transitional or aftercare services or service coordination that will be offered by the program.

(f) Incident reporting. A written description of any injury, accident, or unusual incident involving a child in care must be placed in the individual child in care's record.

(4) Financial records. A therapeutic boarding school must keep a written record for each child in care, itemizing all money received or disbursed on behalf of the child in care. The record must include all of the following:

(a) The date of each receipt and disbursement and the amount of each.

(b) The source of income.

(c) The purpose of each disbursement.

(d) The signature of the person making each entry.

(e) The signature of the child in care for each entry.

(5) The therapeutic boarding school will ensure, in policy, that:

(a) Disallowable items are either stored, or returned to the parent or legal guardian; and

(b) All money and personal belongings are returned to the child in care at the time of discharge.

Stat. Auth.: ORS 409.050, 418.005, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.005, 418.327, OL 2016, ch 10
Hist.: CWP 34-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0701
Homeless, Runaway, and Transitional Living Shelters, What Law Applies

(1) These rules, OAR 413-215-0701 to 413-215-0766, regulate a child-caring agency that provides residential services for homeless or runaway youth, pregnant or parenting girls, or other youth working towards independent living.

(2) A child-caring agency that provides residential services for homeless or runaway youth pregnant or parenting girls, or other youth working towards independent living must also comply with OAR 413-215-0001 to 413-215-0131.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10

Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0706
Definitions

As used in OAR 413-215-0701 to 413-215-0766:

(1) "*Agency*" means a private child-caring agency (defined in OAR 413-215-0006) that operates a shelter, mass shelter, or transitional living program for homeless or runaway youth, for pregnant or parenting girls, or for other youth under the age of 18 working towards independent living.

(2) "Department" means the Department of Human Services.

(3) "Homeless or runaway youth" means a youth who has not been emancipated by the juvenile court; lacks a fixed, regular, safe, and stable nighttime residence; and cannot immediately be reunited with his or her family.

(4) "Individual service plan" means a plan of services to be provided to a youth, based on the identified needs of the youth, designed to help the youth reach mutually agreed upon goals.

(5) "Mass shelter" means a structure that contains one or more open sleeping areas in which, on a daily basis, only emergency services are provided to homeless or runaway youth, such as a meal and a safe place to sleep overnight.

(6) "Shelter" means a facility operated by a *private child-caring agency* that provides services for a limited duration to homeless or runaway youth.

(7) "Transitional living program" means a set of services offered by a private child-caring agency that provides supervision and comprehensive services for up to 18 months to assist homeless or runaway youth to make a successful transition to independent and self-sufficient living.

(8) "Youth" means an unmarried person under the age of 18.

Stat. Auth.: ORS 409.050, 418.005, 418.240
Stats. Implemented: ORS 418.205 - 418.310
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0711
Governance of the Agency

In addition to the governing board requirements in OAR 413-215-0021:

(1) A child-caring agency must be directed by a governing board composed of a representative cross-section of the community, including children in care, parents, and employees of the agency.

(2) A child-caring agency must provide training to the governing board designed to orient the members to the goals, objectives, and activities of the agency.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0716
Client Rights

(1) A child-caring agency must ensure that children in care are actively involved in the design, delivery, and ongoing planning of the services provided by the program.

(2) A child-caring agency must ensure that nutritional needs are met as appropriate for each child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0721
Staffing Requirements

(1) A child-caring agency must have and follow written policies regarding minimum staffing requirements, including a written staffing plan that indicates the number of paid and volunteer staff in each job category.

(2) During each shift, there must be at least one staff member who has been trained in a non-violent crisis intervention strategy. A volunteer or intern may be used to meet this requirement only if the volunteer or intern has met the training requirements for staff in OAR 413-215-0736.

(3) A child-caring agency must have a ratio of staff to children in care that is sufficient to ensure that youth receive adequate supervision and services.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0726
Staff Development and Training

A child-caring agency must follow all of the following requirements:

(1) Initial training. Before being alone with a child in care or being temporarily the only staff in charge of one or more children in care, a staff member must receive the following training or acquire the following knowledge or understanding, as verified by the executive director or the executive director's designee:

(a) Successful completion of the agency's orientation.

(b) Effective understanding of the supervision structure at the shelters of the agency, including the appropriate staff to contact when questions or problems arise.

(c) Effective understanding and knowledge of and compliance with the behavior management policies of the agency.

(d) Recognition and management of the presenting issues of the children in care served, including mental health, behavioral, and substance abuse issues.

(e) Instruction in safety procedures and safe use of equipment.

(f) Sanitation procedures.

(g) First aid kit contents and use.

(h) Report writing, including documentation of medication dispensing and critical incident reports.

(i) Certification to provide cardiopulmonary resuscitation (CPR) and first aid.

(j) Completion of training in crisis intervention.

(2) Ongoing training. A child-caring agency must provide ongoing training for all paid and volunteer staff to increase knowledge, skills, and abilities in each of the following subject areas:

(a) Confidentiality requirements.

(b) Universal precautions (infection control guidelines designed to protect workers from exposure to diseases spread by blood and certain body fluids) and hygiene.

(c) Discipline and behavior management.

(3) Staff must receive training in cardiopulmonary resuscitation and first aid sufficient to retain a current certification.

(4) Staff working with food must possess a food handler's card.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0731
Admissions and Assessments

A child-caring agency must follow all of the following requirements, except with respect to a mass shelter:

(1) The child-caring agency must provide services to children in care according to written policies that list the specific criteria under which children in care are accepted for placement.

(2) Assessment. To determine the appropriateness of each child in care who has applied for services provided by the agency, the agency must make reasonable efforts to gather all of the following basic background information:

(a) Family history.

(b) Health history, including a history of substance abuse as well as current use of prescription and over-the-counter medication.

(c) Mental health history, including diagnoses, a description of behavior problems, prior evaluations, and treatment history.

(d) Who has legal custody of the child in care.

(3) Each assessment must include a statement about whether or not the child in care meets the eligibility requirements necessary to be admitted into the program.

(4) Prior to admitting a child in care, the agency must provide the child in care with an explanation of the available services and the requirements for participation.

(5) After a child in care is admitted, the assessment must be the basis for the child in care's service plan.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0736
Service Planning

A child-caring agency must follow all of the following requirements, except with respect to a mass shelter:

(1) The child-caring agency must make services available that will meet the needs of each child in care in the program.

(2) The child-caring agency must serve each child in care according to a service plan based on the assessment.

(a) Whenever possible, the service plan must include the child in care and his or her family, staff, and other involved parties.

(b) The program must provide competent and individualized service planning for each child in care that includes at least a monthly review of the service plan and changes as needed.

(c) The service plan must address, at a minimum, the child in care's physical and medical needs, behavior management issues, mental health treatment needs, education plans, and any other special needs.

(3) The child-caring agency must make reasonable efforts to ensure participation by the child in care's family in all aspects of the service and service planning process whenever possible. To the extent such information is reasonably available to the agency, the staff of the agency must:

(a) Contact a parent or legal guardian of the child in care early in the process, preferably within 24 hours but no later than 72 hours following the child in care's admission into the program.

(b) Make a program orientation available to the child in care's family.

(c) Encourage participation by a parent in the program. If the child in care's parent cannot participate in the program, the agency must encourage participation by those responsible for the child in care's environment prior to admission.

(d) Consider the family's responsibility, needs, and values in the planning and service process.

(e) When appropriate, the agency must review individual service plans and the child in care's progress with the family at least on a monthly basis.

(4) Directly or through referral, the agency must make available individual, group, and family counseling by a qualified professional.

(5) The child-caring agency must establish and maintain links to community agencies and individuals who can provide required services to children in care or their families that may not be directly available from the program. These services must include:

(a) Alternative living arrangements.

(b) Medical services.

(c) Mental health services.

(d) Educational services.

(e) Independent living services.

(f) Other assistance required by children in care or their families.

(6) Discharge summary. The child-caring agency must prepare a written discharge summary of each child in care served by the program and retain this document in the youth's file. The document must include:

(a) A summary of the child in care's participation in the program and the progress achieved.

(b) Results of evaluations of the child in care.

(c) Condition of the child in care.

(d) The youth's compliance with the program guidelines of the agency.

(e) Recommendations regarding services.

(f) Discharge destination.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0741
Client Files

(1) General requirements. Except with respect to children in care in a mass shelter service plan operated by the child-caring agency, an agency must maintain an individual file on each child in care admitted into the program.

(2) Child in care file requirements. A child-caring agency must have a file on the premises for each child in care currently receiving services from the agency. To the extent such information is reasonably available to the agency, this file must be up to date and include all of the following:

(a) Sufficient information about the child in care's family or legal guardian to enable the staff of the agency to contact them at any time.

(b) Custody status of the child in care.

(c) An authorization for medical treatment.

(d) A signed consent for the agency to treat the child in care with the interventions in use at the program.

(e) A signed acknowledgment that the child in care is responsible for requesting their medication at the prescribed times.

(f) The assessment described in OAR 413-215-0731.

(g) The service plan required by OAR 413-215-0736.

(h) Documentation about the child in care's illnesses and injuries, including the follow up that was provided by the agency.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0746
Medication Storage and Dispensing

(1) A child-caring agency must have and follow written policies on the storage, dispensing, and disposal of prescription and non prescription medication.

(2) Medication storage. All prescription and non-prescription medications must be contained in locked storage in the facility and must be kept in a manner that makes them inaccessible to child in care.

(3) Medication dispensing.

(a) Children in care are expected to administer their own medication after they have requested their medication from the program staff at the prescribed times.

(b) Except in a mass shelter, medication, including non-prescription drugs, may not be dispensed unless the medication has been prescribed or authorized by a qualified professional.

(c) Program staff may not dispense medication to a child in care in any of the following situations:

(A) In excess of the prescribed or authorized amount.

(B) For disciplinary purposes.

(C) For the convenience of staff.

(D) As a substitute for appropriate treatment services.

(4) Documentation. Staff designated to dispense medications must document each dispensing. The documentation must include all of the following:

(a) The child in care's name.

(b) The name of the medication.

(c) The date and time the medication was dispensed.

(d) The dosage given.

(e) The name of the staff member who dispensed the medication.

(5) Disposal of unused or abandoned medication. Designated program staff must dispose of all medication abandoned by a child in care or for which the period of potency, as indicated on the label, has passed. Two staff members must be present at and document the disposal of the unused medication, including when and how the medication was disposed.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0751
Health and Hygiene

(1) A child-caring agency must have and follow policies that ensure the prompt and accurate assessment and care of injuries, illness, and physical complaints of children in care.

(2) A child-caring agency must provide children in care with access to a bathroom and a shower.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0756
Grouping

(1) A child-caring agency must have and follow written policies regarding the grouping of children in care.

(2) Except as provided in section (3) of this rule, an agency must place children in care in groups based on the following factors:

(a) Age.

(b) Developmental level.

(c) Physical maturity.

(d) Social maturity.

(e) Behavioral functioning.

(f) Cognitive level.

(g) Medical concerns.

(h) Individual needs.

(3) A child in care with a diagnosed disability may be served in the most integrated setting appropriate to the needs of the child in care within the context of the program. For purposes of this section:

(a) The child in care who can meet the essential eligibility requirements for a group with or without reasonable modification of rules, policies

or procedures, or the provision of auxiliary aids and services may be served.

(b) "Integrated Setting" means a setting that enables children in care with disabilities to interact with non-disabled persons to the fullest extent possible.

(4) Placement with adults. A child-caring agency may place children in care in the same group as emancipated children in care or adults only after taking special care to assess and minimize the risk to the children in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0761
Safety

A child-caring agency must meet all of the following requirements related to safety:

(1) Fire safety. Prior to licensure and every two years upon license renewal, the program must be assessed and approved by the State Fire Marshall or designee for the following fire safety areas:

(a) The child-caring agency must provide fire safety equipment that meets the requirements of applicable building codes and the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020).

(b) The child-caring agency must comply with existing state and local fire safety codes.

(2) Emergency plan.

(a) The child-caring agency must have, for each facility it operates, a written emergency plan that includes:

(A) Instructions for evacuation of children in care and employees in the event of fire, explosion, accident, or other emergency.

(B) Instructions for response in the event of a natural disaster, external safety threat, or other emergency.

(b) Telephone numbers for local police and fire departments and other appropriate emergency numbers must be posted near all telephones.

(c) Operative flashlights sufficient in number must be readily available to the staff in case of emergency.

(3) Transporting youth. If a child-caring agency uses a vehicle to transport a child in care participating in a program, the child-caring agency must ensure that all of the following requirements are met:

(a) The vehicle is:

(A) Properly registered.

(B) Covered by insurance for personal injury and liability.

(C) Maintained in a safe condition.

(D) Equipped with a first aid kit.

(E) Equipped with a fully charged fire extinguisher that is properly secured and not readily available to children in care.

(b) Each driver must have an Oregon driver license valid for the vehicle used and must comply with all applicable traffic laws while transporting children in care.

(c) Each person in the vehicle rides in a permanent seat, properly using the passenger restraint device in accordance with Oregon law when traveling on public roads.

(d) The child-caring agency must ensure that each person who transports children in care in a van for 15 or more passengers receives training in the safe operation of the type of vehicle prior to transporting youth.

(4) Contraband. A child-caring agency must require its staff to confiscate items prohibited by the child-caring agency that are found in the possession of a child in care. All such items must be disposed of or stored for a child in care in a secure location that is inaccessible to children in care.

(5) Searches. A child-caring agency that conducts a search must have and follow written policies on searches that, at a minimum, meet all of the following requirements:

(a) Require appropriate consent to search a child in care, staff, or a visitor.

(b) Require the use of the least intrusive manner possible for a search.

(c) Pat-down searches. Authorize staff to conduct pat-down searches of children in care, but only when the child-caring agency determines the search is necessary to discourage the introduction of contraband or to promote the safety of staff and other children in care. If a pat-down search is used:

(A) The search must be conducted by same gender staff members trained in proper search techniques.

(B) The search must be conducted in the presence of another staff member.

(C) The child in care must be given warning of the search.

(D) Prior to the search, the child in care should remove all outer clothing, for instance, gloves, coat, hat, and shoes, and empty all pockets.

(E) Once the child in care has removed all outer clothing, the staff member conducting the search must then pat the clothing of the child in care using only enough contact to conduct an appropriate search.

(F) If anything suspicious is detected during the search, the child in care must be asked to identify the item, and appropriate steps should be taken to make the item available for inspection.

(G) If the child in care refuses to comply with a requirement of the search, the program must follow established policies to determine if the child in care can be refused admission to or discharged from the program.

(d) Prohibit the use of strip searches of children in care.

(e) Prohibit the use of body-cavity searches of children in care.

(6) Building Requirements.

(a) A child-caring agency may not allow children in care to have access to, or provide services regulated by these rules (OAR 413-215-0701 to 413-215-0766) in, a building unless the building has been certified as meeting all applicable state and local construction-related requirements for a building used as a residential facility, including the Oregon Structural Specialty Code (see the current version of OAR 837-040-0140), the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020), the rules of the Public Health Division of the Oregon Health Authority (see the current requirements for buildings in OAR chapter 333), the Oregon Plumbing Specialty Code (see the current version of OAR 918-750-0110 to OAR 918-750-0140), the rules of the State Fire Marshal (see the current requirements for buildings in OAR chapter 837), and the local building, fire, and safety codes.

(b) A child-caring agency must ensure that all of the following standards are met:

(A) All buildings where children in care are present must be smoke-free.

(B) All buildings where children in care are present must be kept clean and in good repair. Major appliances and heating, ventilation, plumbing and electrical systems must be functional and in good repair.

(C) Water temperature and access to water:

(i) A continuous supply of hot and cold water, installed and maintained in compliance with this rule, must be distributed to taps conveniently located throughout each building used to provide services or housing for children in care.

(ii) The temperature of hot water used for hand washing, bathing, or showering must be controlled so that it does not exceed 120 degrees Fahrenheit in each building used to provide services or housing for children in care.

(iii) Each child in care who lacks the ability to adjust and control water temperature safely must be directly supervised by a staff member of the child-caring agency.

(D) Heating and ventilation. Room temperatures must be maintained within normal comfort range. Buildings must be ventilated and free of excessive heat and condensation and of unpleasant odors.

(c) Bathrooms.

(A) Bathrooms must be provided and be conveniently located in each building containing children in care, and must have all of the following:

(i) A minimum of one toilet and one hand-washing sink with mixing faucets for each eight children in care.

(ii) A self-closing metered faucet, if used, that provides water flow for at least 15 seconds without a need to reactivate the faucet.

(iii) Hot and cold running water, as well as soap and paper towels available at sinks or other hand-drying options approved by the local health department.

(iv) One bathtub or shower for each 10 children in care.

(v) Arrangements for individual privacy of children in care.

(vi) A window covering on each window to ensure privacy.

(vii) Permanently-wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(viii) A mirror, permanently affixed at eye level.

(ix) Adequate ventilation.

(B) Use of wooden racks over shower floors is prohibited.

(C) When impervious shower mats are used, they must be disinfected and dried at least once per day.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.310, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0766
Environmental Health

A child-caring agency must meet all of the following requirements:

(1) The program of the agency must maintain an environment that ensures safety for program staff and children in care.

(2) Environmental Health Specialist approval. Prior to licensure and every two years upon license renewal, the program must be assessed and provide documentation of approval by a registered environmental health specialist (see OAR 338-010-0025 to 338-010-0038) for the following safety areas:

(a) Food service risk assessment.

(b) Drinking water or waste water assessment.

(c) Vector and pest control, including the use of pesticides and other chemical agents.

(d) Hazardous material management, including handling and storage.

(e) Recreation assessments (such as playgrounds, swimming pools, and hot tubs) for injury prevention and hazard mitigation.

Stat. Auth.: ORS 409.050, 418.005, 418.240, 418.327, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.327, OL 2016, ch 10
Hist.: CWP 35-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0801
Day Treatment Agencies, What Law Applies

(1) These rules, OAR 413-215-0801 to 413-215-0856, regulate a child caring agency that provides day treatment services subject to the certificate of approval requirements of OAR 309-032-1120 must:

(a) Comply with OAR 413-215-0001 to 413-215-0131; and

(b) Comply with all requirements of OAR 309-022-0100 to 309-022-0230 applicable to providers of psychiatric day treatment.

(2) OAR 413-215-0801 to 413-215-0856 do not apply to a program that provides residential care under OAR 413-215-0501 to 413-215-0586, an academic boarding school (OAR 413-215-0201 to 413-215-0276), or a therapeutic boarding school (OAR 413-215-0601 to 413-215-0681).

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0806
Definitions

As used in OAR 413-215-0801 to 413-215-0856:

(1) "Clinical supervisor" means a Qualified Mental Health Professional with two years post-graduate clinical experience in a mental health treatment setting. The clinical supervisor, as documented by the provider, operates within the scope of his or her practice or licensure, and demonstrates the competency to oversee and evaluate the mental health treatment services provided by other Qualified Mental Health Professionals or Qualified Mental Health Associates.

(2) "Day treatment" means a comprehensive, interdisciplinary, non-residential, community-based, psychiatric treatment, family treatment, and therapeutic activities integrated with an accredited education program provided to children with emotional disturbances.

(3) "Day treatment agency" means a *private child caring agency* (defined in OAR 413-215-0006) that provides day treatment services subject to 309-032-1100 to 309-032-1230.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0811
Staff Qualifications and Minimum Staffing Requirements

(1) A day treatment agency must utilize teachers licensed in accordance with the requirements of the Teachers Standards and Practices Commission.

(2) A qualified clinical supervisor must direct the clinical program and supervise clinical staff.

(3) A day treatment agency must employ mental health service delivery staff who meet the qualifications described at OAR 309-032-1110(70) — (72).

(4) A day treatment agency must have sufficient Qualified Mental Health Professionals (QMHP) and other staff on duty to meet the severity and acuity of children in care served by the day treatment agency. In no case may the ratio of children to QMHP on duty be more than 12 children for each QMHP.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0816
Physical Plant Requirements

A day treatment agency must meet all of the following requirements:

(1) All buildings owned, maintained, or operated by the day treatment agency to provide services to children must meet all applicable state and local building, electrical, plumbing, and zoning codes.

(2) All areas of the facility must be kept clean and in good repair. Major appliances and heating, ventilation, plumbing, and electrical systems must be functional and in good repair.

(3) Each room used by children in care must have floors, walls, and ceilings which meet the interior finish requirements of the applicable Oregon Structural Specialty Code (see the current version of OAR 837-040-0140) and the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020) and be free of harmful drafts, odors, and excessive noise.

(4) Each room used by children in care must be adequate in size and arrangement for the purpose in which it is used.

(5) A system providing a continuous supply of hot and cold water must be distributed to taps conveniently located throughout the facility.

(6) Water systems serving the property must be installed and maintained in compliance with the applicable Oregon Health Authority Public Health Division drinking water regulations (ORA chapter 333).

(7) Heat and ventilation.

(a) Buildings must be ventilated by natural or mechanical means and must be free of excessive heat, condensation, and obnoxious odors.

(b) Room temperature must be maintained within a normal comfort range.

(8) Individual Rooms.

(a) Restrooms must be provided and be conveniently located, and must have:

(A) A minimum of one toilet for every 15 children in care.

(B) One hand-washing sink with mixing faucets for every two toilets. The sink may not be used for the preparation of food or drinks or for dish washing.

(C) Hot and cold running water, soap, and paper towels at each hand washing sink or other hand drying options approved by an environmental health specialist.

(D) Arrangements for individual privacy for children in care.

(E) Permanently wired light fixtures located and maintained so as to give adequate light to all parts of the room.

(F) A window covering on each window to ensure privacy.

(G) A mirror, permanently affixed at eye level.

(H) Adequate ventilation.

(I) Each self-closing metered faucet, if provided, must provide water flow for at least 15 seconds without the need to reactivate the faucet.

(b) Laundry facilities, when provided, must be separate from;

(A) Kitchen and dining areas; and

(B) Areas used for the storage of unrefrigerated perishable food.

(c) Storage areas must be provided appropriate to the size of the facility. Separate storage areas must be provided for:

(A) Food, kitchen supplies, and utensils.

(B) Clean linens.

(C) Soiled linens and clothing.

(D) Cleaning compounds equipment.

(E) Poisons, chemicals, pest control products, insecticides, and other toxic materials, which must be properly labeled, stored in the original container, and kept in a locked storage area.

(F) Outdoor recreational and maintenance equipment.

(d) Food service areas.

(A) Kitchens must have facilities for dish washing, storage, and preparation of food and must be separate from child-caring areas.

(B) The walls, floors, and floor coverings of all rooms in which food or drink is prepared or stored or in which utensils are washed or stored must be smooth, washable, and easily cleanable.

(C) All equipment and utensils used for food service, including plastic ware and food-contact surfaces, must be easily cleanable, durable, nontoxic, and non-absorbent and must be maintained in a clean and sanitary condition.

(D) All equipment used for food preparation must be installed and maintained in a manner providing ease of cleaning beneath, around, and behind each unit.

(e) Classrooms and school buildings must be adequate in size and arrangement for the programs offered.

(f) Time-out rooms. Rooms used for time out or quiet time must have adequate space, heat, light, and ventilation and must not be capable of locking.

(g) A usable recreational activity area must be provided that is protected from motor traffic and other hazards, of a size and availability appropriate to the age and the needs of the children in care served by the day treatment agency.

(9) Furnishings and personal items.

(a) A day treatment agency must provide appropriate furniture for a learning environment.

(b) Each child in care must have a storage area available, such as a locker or other separate space to store personal items.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0821
Building Plans for New Facility or Remodel

A day treatment agency must meet all of the following requirements:

(1) A set of plans and specifications for each day treatment facility operated by the day treatment agency must be submitted to the Department and to the State Fire Marshal for approval:

(a) Prior to construction of a new building;

(b) Prior to construction of an addition to an existing building;

(c) Prior to the remodeling, modification, or conversion of a building; and

(d) In support of an application for initial license of a day treatment agency not previously licensed under OAR 413-215-0801 to 413-215-0856.

(2) The required plans must comply with both current Oregon Structural Specialty Codes (see OAR 837-040-0140) and local fire and safety codes.

(3) Plans must be drawn to scale and must specify the estimated date upon which construction, modification, or conversion will be completed.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0826
Environmental Health

A day treatment agency must meet all of the following requirements:

(1) The program of the day treatment agency must maintain an environment that ensures safety for program staff and children in care.

(2) Environmental Health Specialist approval. Prior to licensure and every two years upon license renewal, the program must be assessed and provide documentation of approval by a registered environmental health specialist (see OAR 338-010-0025 to 338-010-0038) for the following safety areas:

(a) Food service risk assessment.

(b) Drinking water or waste water assessment.

(c) Vector and pest control, including the use of pesticides and other chemical agents.

(d) Hazardous material management, including handling and storage.

(e) Recreation assessments (such as playgrounds, swimming pools, and hot tubs) for injury prevention and hazard mitigation.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0831
Food Services

A day treatment agency must meet all of the following requirements related to food services:

(1) Nutrition and dietary requirements.

(a) A day treatment agency must arrange meals daily, consistent with normal mealtimes that occur during hours of operation.

(b) Menus must be prepared in advance in accordance with USDA guidelines and must provide a sufficient variety of foods served in adequate amounts for each child at each meal, adjusted for seasonal changes. Records of menus as served must be maintained in the facility record for at least six months.

(c) Drinking water must be freely available to the children in care served by the day treatment agency.

(2) Food selection, storage, and preparation.

(a) All food and drink provided by the agency must be stored, prepared, and served in a sanitary manner.

(b) All employees who handle food served to children in care must have a valid food handler's card pursuant to ORS 624.570.

(c) Selection of food. All food products served by a day treatment agency must be obtained from commercial suppliers, except that:

(A) Fresh fruits and vegetables and fruits or vegetables frozen by the day treatment agency may be served.

(B) The serving of unpasteurized juice is prohibited.

(d) Requirements related to milk.

(A) Only Grade A pasteurized and fortified milk may be served to children in care.

(B) Milk and fluid milk products must be dispensed from a commercially filled plastic container of not more than one-gallon capacity or from a refrigerated bulk container equipped with a dispensing device approved by the Food and Drug Administration or Oregon Department of Agriculture.

(e) Children in care may participate in activities in a food-preparation area, other than routine clean up, only while under the supervision of the employees of the day treatment agency.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0836
Safety

A day treatment agency must meet all of the following requirements related to safety.

(1) Fire safety. Prior to licensure and every two years upon license renewal, the program must be assessed and approved by the State Fire Marshall or designee for the following fire safety areas:

(a) The day treatment agency must provide fire safety equipment that meets the requirements of applicable building codes and the Oregon Fire Code (see the current version of OAR 837-040-0010 and 837-040-0020).

(b) The day treatment agency must comply with existing state and local fire safety codes.

(2) Emergency plan.

(a) The day treatment agency must have, for each facility it operates, a written emergency plan that includes:

(A) Instructions for evacuation of children in care and employees in the event of fire, explosion, accident, or other emergency.

(B) Instructions for response in the event of a natural disaster, external safety threat, or other emergency.

(b) Telephone numbers for local police and fire departments and other appropriate emergency numbers must be posted near all telephones.

(c) Operative flashlights sufficient in number must be readily available to the staff in case of emergency.

(3) Evacuation drills.

(a) An unannounced evacuation drill must be held monthly under varying conditions to simulate the unusual conditions that occur in the event of fire. For each drill, the day treatment agency must document the following information and retain it for a minimum of two years:

(A) Identity of the person conducting the drill.

(B) Date and time of the drill.

(C) Notification method used.

(D) Staff members on duty and participating.

(E) Number of children in care and staff evacuated.

(F) Special conditions simulated.

(G) Problems encountered.

(H) Time required to accomplish complete evacuation.

(b) The day treatment agency must ensure that all employees and children in care are aware of the procedures to follow in case of emergencies.

(4) Hazards.

(a) The day treatment agency must protect children in care from guns, drugs, plastic bags, sharps, paint, hazardous materials, bio hazardous materials, and other potentially harmful materials. A day treatment agency must have a written policy that prevents potentially harmful materials that are in the building accessible to the children in care or on the grounds of the program.

(b) The temperature of hot water used for hand washing, bathing, or showering must be controlled so that it does not exceed 120 degrees Fahrenheit in all buildings serving children. Direct supervision by staff must be provided for any child in care who does not have the ability to adjust and control water temperature.

(c) Each light fixture must have a protective cover unless it is designed to be used without one.

(5) Transportation. The day treatment agency must ensure the following when providing transportation to children in care:

(a) Driver requirements.

(A) Each employee transporting children in care in a motor vehicle must have a valid current driver license on record with the day treatment agency.

(B) The day treatment agency may use an employee to provide transportation for children in care only if the employee is covered by an insurance policy in full force and effect, and in compliance with the standards set by the day treatment agency.

(C) The day treatment agency must ensure that employees providing transportation are trained in emergency procedures, including behavior management, while in a vehicle.

(D) The day treatment agency must ensure that each person who transports a child in care in a van for 15 or more passengers receives training in the safe operation of that type of vehicle prior to transporting children.

(b) Vehicle requirements.

(A) Each vehicle used to transport a child in care served by the day treatment agency must be covered by an insurance policy in full force and effect.

(B) Each vehicle used to transport a child in care served by the day treatment agency must be maintained in safe operating condition.

(C) Each vehicle used to transport a child in care must have aboard a first aid kit, a fully charged and working fire extinguisher with a rating of at least 2 A:10 BC, and a copy of the medical insurance card of each child being transported.

(D) Each vehicle used to transport a child in care must be smoke-free.

(E) Children in care and adults must ride in a vehicle manufactured seat, properly using the passenger restraint device in accordance with Oregon law when traveling on public roads.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0841
Health Services

A day treatment agency must provide oversight of the clinical aspects of health care provided to children in care and must provide psychiatric on-call consultation at all times.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0846
Medication

A day treatment agency must comply with all of the following requirements:

(1) Policy and procedures. The day treatment agency must have policies and procedures that cover prescriptions, herbal remedies, and all non-prescription medications that address all of the following:

(a) How the medication will be administered.

(b) By whom the medication will be administered.

(c) How the staff of the day treatment agency who administer medication will be trained.

(d) How the administration of medication will be documented.

(e) How the administration of medication will be monitored.

(f) How unused medication will be disposed of.

(g) The process that ensures that each child in care's prescription and non-prescription medications are reviewed, unless the medications are all provided through a single pharmacy. As used in this rule, "non prescription medication" means any medication that does not require a written prescription for purchase or dispensing.

(2) A prescription, signed by a physician or other qualified medical professional, is required before any prescription medication is administered to, or self-administered by a child in care. Medications prescribed for one child in care may not be administered to, or self-administered by another child in care or staff. As used in this rule "self-administration" refers to the act of a resident placing a medication internally in, or externally on, his or her own body.

(3) A written order, signed by a physician or other qualified medical professional, is required for any medical treatment, special diet, physical therapy, aid to physical functioning, or limitation of activity.

(4) Before a day treatment agency permits a child in care to self-administer prescription medication, self-administration must be recommended by the day treatment agency, approved in writing by a physician, and closely monitored by the child in care's guardian or the staff of the day treatment agency.

(5) Medication storage.

(a) Prescription medications that are unused and any medications that are outdated or recalled may not be maintained in the facility. "Outdated" means any medication whose designated period of potency, as indicated on the label, has expired.

(b) The facility may maintain a stock supply of non-prescription medications.

(c) All prescription and non-prescription medications must be contained in locked storage in the facility and must be kept in a manner that makes them inaccessible to children.

(d) Medications requiring refrigeration must be refrigerated and secured.

(e) Medications must be maintained and stored in their original container, including the prescription label.

(6) Medication disposal. Medications must be disposed of in a manner that ensures that they cannot be retrieved, in accordance with all applicable state and federal law.

(7) A written record of all medication disposals must be maintained and must include all of the following:

(a) A description of the prescribed medication and the amount disposed.

(b) The child in care for whom the medication was prescribed.

(c) The reason for disposal.

(d) The method of disposal.

(e) The name of the adult disposing the medication, and the initials of an adult witness.

(8) Medication records. A written record must be kept for each child in care listing all medications, both prescription and over-the-counter, that are administered. The record must include all of the following:

(a) The name of the child in care.

(b) A description of the medication, instructions for use, and the recommended dosage.

(c) Dates and times medication is administered.

(d) A record of missed dosages.

(e) Medication dropped or disposed of.

(f) Method of administration for each medication.

(g) Identification of person administering the medication.

(h) Any adverse reactions to the medication.

(i) Documentation of any medication taken outside the facility by a child in care during a home visit or other activity.

(9) Where applicable, the day treatment agency must maintain documentation of the continuing evaluation of the child's ability to self-administer a medication.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0851
Requirement to Have Policies and Procedures

A day treatment agency must have a written policy that includes the following:

(1) Hours of operation.

(2) Service area.

(3) Family expectations and participation requirements.

(4) Type of behavioral and affective characteristics of the children in care.

(5) Psychiatric, therapeutic, or counseling services offered.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0856
Educational Services

The educational services of a day treatment agency must comply with all of the following requirements:

(1) The day treatment agency must comply with the minimum requirements for private education institutions as determined by the Oregon Department of Education.

(2) Education services must include at least one qualified teacher for every fifteen children in care.

(3) The day treatment agency must ensure it has a curriculum that considers the goals of modern education as defined in OAR 581-022-1020 and the requirements of a sound, comprehensive curriculum.

(4) Secondary schools must verify that they have academic standards necessary for children in care to obtain admission to community colleges, institutions of higher education, and receive a high school diploma or GED.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, OL 2016, ch 10
Hist.: CWP 36-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0901
Applicability and General Provisions

(1) Required compliance. These rules, OAR 413-215-0901 to 413-215-1031, regulate a child caring agency licensed as an outdoor youth program subject to Oregon laws governing child caring agencies, ORS 418.205 to 418.325 and 418.990 to 418.998 and Oregon laws governing outdoor youth programs, ORS 418.205 to 418.246. An outdoor youth program must also comply with OAR 413-215-0001 to 413-215-0131.

(2) Stationary Outdoor Youth Program additional license requirement. An outdoor youth program that operates as a stationary outdoor youth program must secure an Organizational Camp License as described in OAR 333-030-0005 to 333-030-0130 from the Oregon Health Authority, Public Health Division.

(3) Bond required. Each outdoor youth program applying for licensure must file with the Department a Fiduciary Bond in the amount of $50,000 or 50 percent of the program's yearly budget, whichever amount is less. The Bond must be issued by a surety or insurer that is licensed to do business in the State of Oregon. The Bond must be written and issued on the Surety Bond Form (DHS CF 1066), provided to the outdoor youth program by the Department. The required Bond must be continuous until canceled and must remain in full force at all times to comply with this section. Any claims or potential impairment to the Bond must be reported to the Department within 30 days of the incident or occurrence involving the claim or potential impairment. In the event of impairment to the Bond, the outdoor youth program will be required to obtain additional bonding to satisfy the requirements of this section. The surety or insurer must give the Department at least 30 days written notice before canceling or terminating its liability under the Bond. An action on the Bond may be brought by any person aggrieved by the misconduct of an outdoor youth program required to be licensed under ORS 418.205 to 418.310. As evidence of the Bond, the outdoor youth program must keep a certified copy of the Bond on file with the Department at all times.

(4) Workers' Compensation. An outdoor youth program must comply with all provisions of ORS 656.017 and provide the required Workers' Compensation coverage, unless such employers are exempt under ORS 656.126. The outdoor youth program must ensure that each of its subcontractors complies with these requirements.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; CWP 1-2004, f. & cert. ef. 1-9-04; Renumbered from 413-210-0800, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0906
General Provisions

(1) License required. *No private child-caring agency* (defined in OAR 413-215-0006) may operate an outdoor youth program (defined in 413-215-0911) in Oregon without a valid license issued by the Department in accordance with 413-215-0001 to 413-215-0131 and 413-215-0901 to 413-215-1031.

(2) Compliance required. Any agency which provides the services of an *outdoor youth program* must comply with these rules governing outdoor youth programs (OAR 413-215-0901 to 413-215-1031) and 413-215-0001 to 413-215-0131.

(3) Stationary *Outdoor Youth Program* additional license requirement. An *outdoor youth program* that operates as a stationary outdoor youth program (defined in OAR 413-215-0911) must secure an Organizational Camp License as described in OAR 333-030-0005 to 333-030-0130 from the Oregon Department of Human Services, Public Health Division.

(4) Bond required. Each outdoor youth program applying for licensure must file with the Department a Fiduciary Bond in the amount of $50,000 or 50 percent of the program's yearly budget, whichever amount is less. The Bond must be issued by a surety or insurer that is licensed to do business in the State of Oregon. The Bond must be written and issued on the Surety Bond Form (DHS CF 1066), provided to the outdoor youth program by the Department. The required Bond must be continuous until canceled and must remain in full force at all times to comply with this section. Any claims or potential impairment to the Bond must be reported to the Department within 30 days of the incident or occurrence involving the claim or potential impairment. In the event of impairment to the Bond, the outdoor youth program will be required to obtain additional bonding to satisfy the requirements of this section. The surety or insurer must give the Department at least 30 days written notice before canceling or terminating its liability under the Bond. An action on the Bond may be brought by any person aggrieved by the misconduct of an outdoor youth program required to be licensed under ORS 418.205 to 418.310. As evidence of the Bond, the outdoor youth program must keep a certified copy of the Bond on file with the Department at all times.

(5) Workers' Compensation. An outdoor youth program must comply with all provisions of ORS 656.017 and provide the required Workers' Compensation coverage, unless such employers are exempt under 656.126. The outdoor youth program must ensure that each of its subcontractors complies with these requirements.

Stat. Auth.: ORS 409.050, 418.005, 418.240
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; CWP 1-2004, f. & cert. ef. 1-9-04; CWP 7-2007, f. & cert. ef. 5-1-07; Renumbered from 413-210-0806, CWP 28-2008, f. & cert. ef. 10-17-08; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0911
Definitions

The following definitions apply to OAR 413-215-0901 to 413-215-1031:

(1) "Contraband" means items the possession of which is prohibited by the outdoor youth program such as but not limited to weapons or drugs.

(2) "Debrief" means to interview a person (such as a youth or staff member) usually upon return (as from an expedition) in order to obtain useful information.

(3) "Department" means the Department of Human Services.

(4) "Outdoor living setting" means an outdoor field setting in which services are provided to youth either more than ten days per month for each month of the year or for longer than 48 hours at a location more than two hours from community-based medical services.

(5) "Outdoor youth program" means a program that provides, in an outdoor living setting, services to youth who are enrolled in the program because they have behavioral problems, mental health problems or problems with abuse of alcohol or drugs. "Outdoor youth program" does not include any program, facility or activity operated by a governmental entity, operated or affiliated with the Oregon Youth Conservation Corps, or licensed by the Department as a child caring agency under other authority of the Department. It does not include outdoor activities for youth designed to be primarily recreational.

(6) "Outdoor youth program activity" means an outdoor activity, provided to youth for the purpose of behavior management or treatment, which requires specially trained staff or special safety precautions to reduce the possibility of an accident or injury. Outdoor youth activities include, but are not limited to: hiking, adventure challenge courses, climbing and rappelling, winter camping, soloing, expeditioning, orienteering, river and stream swimming, and whitewater activities.

(7) "Over the counter medication" means any medication that does not require a written prescription for purchase or dispensing.

(8) "Service plan" means an individualized plan of services to be provided to each youth based on his or her identified needs and designed to help him or her reach mutually agreed upon goals. The service plan must address, at a minimum, the youth's physical and medical needs, behavior management issues, mental health treatment methods, education plans, and any other special needs.

(9) "Sole supervision" means being alone with a youth or being temporarily the only staff in charge of a youth or subgroup of youth.

(10) "Stationary outdoor youth program" means an outdoor youth program which remains in a stationary location that houses youth.

(11) "Wilderness first responder" means a medical training course and certification for outdoor professionals.

(12) "Youth" means a child aged 10 through 17 years of age who may be admitted to or is a participant in an outdoor youth program.

Stat. Auth.: ORS 409.050, 418.005, 418.240
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0803, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; Suspended by CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0916
Administration

(1) Base of operations. An outdoor youth program providing outdoor youth program services in Oregon must have a base of operation or field office in Oregon. The base of operation or field office at a minimum must have the following information immediately available upon the request of the Department licensing coordinator:

(a) Current list of the names of staff and children in care in each field group;

(b) Master map of all outdoor youth program activity areas used by the program in Oregon, copies of which must be made available to the Department licensing coordinator, the land managing agency, and local law enforcement and emergency services upon request;

(c) Copies of each group of children in care's expeditionary route with its schedule and itinerary, copies of which must be made available to the Department, the land managing agency and local law enforcement and emergency services upon request;

(d) Current logs of communications with each field group of children in care away from the base of operations; and

(e) Emergency response plan that is reviewed annually (as described in OAR 413-215-0936(2)(c)).

(2) Child in care file requirements. The base of operations for an outdoor youth program must have a file on each child in care in the program, which includes:

(a) Legal guardian identification, contact information, and custody status of child in care;

(b) Emergency contact information for the legal guardian or guardians of the child in care which provides for contact with the parent or legal guardian at any time, twenty four hours a day, seven days a week;

(c) Demographics including but not limited to name, gender, date of birth, and previous address;

(d) Eligibility and exclusionary criteria, including the basis for admission of the child in care into the program;

(e) Medical forms;

(f) Authorization for medical treatment; and

(g) Legal guardian consent for the outdoor youth program to treat the child in care with the specific interventions used by the program and to confiscate contraband found in the youth's possession.

(3) Proof of compliance. An outdoor youth program which operates in Oregon must comply with the federal, state, local, and land managing agency regulations in the operations area and must maintain proof of compliance at the base of operations.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0809, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0918
Consents, Disclosures, and Authorizations

(1) Consents. For each child in care with an outdoor youth program, the outdoor youth program must ensure that the legal guardian signs a consent that authorizes the outdoor youth program to undertake each of the following:

(a) To provide routine and emergency medical care.

(b) To use the discipline and behavior management system of the outdoor youth program, including the point, level, or other behavior management techniques utilized by the outdoor youth program.

(c) If applicable, to use restraint in the management of the child in care. The consent for the use of physical restraint must be limited to the requirements outlined in OAR 413-215-0076(3)(e).

(d) If applicable, to use time outs. The consent for the use of time outs must be limited to the requirements outlined in OAR 413-215-0076(3)(d).

(2) Disclosures to parent or legal guardian. At the time an outdoor youth program takes a child in care into placement, the outdoor youth program must ensure that each legal guardian of the youth receives and acknowledges in writing the receipt of each of the following:

(a) Information regarding any personal searches and protocols for confiscation of contraband items, including the notification of law enforcement if illegal contraband is discovered. This information will include the procedures and rationales of the outdoor youth program for any program-initiated pat down searches.

(b) A statement concerning the rights of child in care and legal guardians served by the outdoor youth program as provided in OAR 413-215-0046. The statement must be written in a manner that is easy to understand, and the outdoor youth program must ensure that the youth and the parent or legal guardian understand the statement.

(c) An outdoor youth program shall provide a copy of transportation policies and procedures to the legal guardians at the time of admission to the program.

(d) An outdoor youth program will disclose orientation procedures to the client and legal guardians at the time of admission to the program and prior to transporting the child in care to the field.

(3) Authorizations. An outdoor youth program must follow the following requirements:

(a) Written authorizations to exchange information with others must be filled out prior to signatures being requested.

(b) All visitors for the child in care must be approved or authorized by the legal guardians, except Department personnel, child abuse investigators, Court Appointed Special Advocates, and attorneys appointed to represent the child in care.

(c) All other visitors must be pre-approved by the child in care's legal guardians.

(d) Activity-specific authorizations must be pre-approved by the child in care's legal guardians to allow children in care to participate in potentially hazardous activities, such as rock climbing, swimming, and horseback riding.

(e) All other required authorizations must be pre-approved by the child in care's legal guardians.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: CWP 7-2013, f. & cert. ef. 10-1-13; CWP 3-2014, f. 1-31-14, cert. ef. 2-1-14; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0921
Participant Clothing, Equipment and Supplies

An outdoor youth program must comply with all of the following requirements:

(1) Participant requirements. Each program participant must have appropriate clothing, equipment, and supplies for each type of outdoor youth program activity and for the weather conditions likely to be encountered.

(2) Clothing, equipment, and supply requirements. Clothing, equipment, and supplies must include at a minimum the applicable items in each of the following subsections:

(a) Sunscreen if appropriate for the environmental conditions generally expected for the area and season.

(b) Insect repellent if appropriate for the environmental conditions generally expected for the area and season.

(c) A commercial backpack or the materials to construct a safe backpack or bedroll.

(d) Personal hygiene items necessary for cleansing.

(e) Appropriate feminine hygiene supplies.

(f) When the average nighttime temperature is expected to be 40 degrees Fahrenheit or higher:

(A) Wool blankets or an appropriate sleeping bag; and

(B) A tarp or poncho.

(g) Shelter from precipitation, appropriate sleeping bag, and ground pad when the average nighttime temperature is expected to be 39 degrees Fahrenheit or lower.

(h) Clothing appropriate for the temperature changes generally expected for the area.

(i) Each child in care must be provided a clean change of undergarments and socks at least once a week or an opportunity to wash his or her clothing at least once a week; and all other clothing must be reasonably clean and in good repair.

(3) Denial of clothing, equipment, and supplies. An outdoor youth program must not remove, deny, or make unavailable for any reason the appropriate clothing, equipment, or supplies required by section (2) of this rule.

(4) Monitoring. Field staff are responsible for maintaining the safety and well-being of children in care and must monitor each child in care to make sure that clothing, equipment, and supplies are maintained in a manner adequate to ensure each child in care's safety.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0868, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0926
Water Requirements

An outdoor youth program must comply with all of the following requirements:

(1) Written policy. An outdoor youth program must have and follow written policy and procedures on water requirements.

(2) Water. Children in care must have access to potable water while engaged in hiking. Staff of the outdoor youth program must ensure that children in care drink a sufficient amount of water to provide adequate hydration. Staff must encourage children in care to consume at least three quarts of potable water a day.

(3) Water caches. When water caches are used, field staff must place each water cache and verify its location in advance of a group's arrival.

(4) Water from a natural source. Water from a natural source used for drinking or cooking must be treated for sanitation to eliminate health hazards. Staff must document what methods were used to sanitize the water.

(5) Electrolytes. Each group must have and use when appropriate a supply of electrolyte replacement, quantities to be determined by group size and environment conditions.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0864, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0931
Nutritional Requirements

An outdoor youth program must comply with all of the following requirements:

(1) Written policy. An outdoor youth program must have and follow written policy and procedures on nutritional requirements.

(2) Menu. There must be a written menu approved by a qualified dietitian or nutritionist with knowledge of program activity levels, listing the food supplies for each group.

(3) Calories. An outdoor youth program must provide each child in care a level of nutrition which will supply the child in care's individual caloric need; but no child in care may be offered less than 3,000 calories a day. When heat is not available for cooking, an outdoor youth program must provide sufficient food of sufficient caloric value which does not require cooking.

(4) Hygiene procedures. The outdoor youth program must have reasonable hygiene procedures to prevent infection which are consistent with the particular program risk of infection.

(a) Cleansing of hands must occur after each latrine use.

(b) Means of cleansing the hands must be available to children in care prior to food preparation and prior to food consumption.

(c) A weekly opportunity for total body hygiene.

(5) Fasting. There must be no imposed fasting.

(6) Monitoring. Field staff are responsible for maintaining the safety and well-being of each child in care and must monitor each child in care's food intake to ensure that the child in care has adequate nutrition.

(7) Food must not be used for behavior modification purposes, including reward or punishment.

(8) Youth must be permitted a reasonable amount of uninterrupted time for each meal.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0866, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0936
Safety

(1) Written policies and procedures. An outdoor youth program must have and follow written policies and procedures on all of the following:

(a) Equipment Safety Procedures, including appropriate instruction and maintenance of equipment.

(b) Environmental Hazards.

(c) Risk Management Procedures.

(d) Health, nutrition, hydration, and physical stress management.

(2) Emergency plan. An outdoor youth program must have and follow a written emergency plan for disasters, medical emergencies, hostage situations, casualties and missing children in care, and other critical incidents identified by the program. The plan must at a minimum include:

(a) Designation of authority and staff assignments;

(b) Plans for evacuation;

(c) An emergency evacuation system that is on standby;

(d) Transportation and relocation of children in care when necessary;

(e) Supervision of children in care after an evacuation or a relocation;

(f) Arrangements for medical care and notification of a child in care's physician and nearest relative, parents, or legal guardian; and

(g) A procedure for a review of the emergency plan by the local law enforcement and emergency services agencies from the area in which the outdoor youth program is operating.

(3) Emergency instruction. An outdoor youth program must instruct children in care on what to do in case of an emergency prior to any outdoor youth program activity.

(4) Emergency plan response review. In the case of the activation of an emergency plan response, the outdoor youth program must subsequently review the response in the context of the emergency plan to determine if changes need to be made to improve safety and efficiency. If local law enforcement and emergency services agencies have been involved in an emergency response on behalf of an outdoor youth program, the outdoor youth program must invite them to participate in the review of the emergency plan response.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0852, 413-210-0855, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0941
Potential Weapons

(1) Written policy. An outdoor youth program must have and follow written policy and procedures on management of weapons and potential weapons.

(2) Inventory required. Staff of an outdoor youth program must inventory knives, hatchets, other edged tools, or any item which might reasonably pose a danger to self or others and complete a daily count of these items against the inventory.

(3) Supervision required. Staff of an outdoor youth program must have line of sight supervision of a child in care who is in possession of and using knives, hatchets, other edged tools, or any item which might pose a danger to self or others.

Stat. Auth.: ORS 409.050, 418.005, 418.240 OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998 OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0870, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0946
Contraband

(1) Written policy. An outdoor youth program must have and follow written policy and procedures on contraband.

(2) Confiscation. Staff must confiscate contraband found in the possession of children in care in an outdoor youth program and, if stored, secure it in a location inaccessible to children in care.

(3) Disposal. It is the responsibility of the outdoor youth program to store or dispose of all contraband not confiscated by or turned over to law enforcement, in accordance with the contraband policy.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0880, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-1; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0951
Searches

(1) Written policy. If an outdoor youth program conducts searches of children in care or visitors, it must have and follow written policies and procedures. The program must obtain the appropriate consents for searches.

(2) Searches. An outdoor youth program must complete searches in the least intrusive manner possible for the type of search being conducted. The policies and procedures at a minimum must address all of the following:

(a) Pat down searches. An outdoor youth program may conduct pat down searches of children in care only when the outdoor youth program judges that it is necessary to discourage the introduction of contraband, or to promote the safety of staff and other children in care. An outdoor youth program may only conduct pat down searches as follows:

(A) By staff trained in proper search techniques;

(B) By a staff member of the same sex as the child in care being searched, and in the presence of another staff member;

(C) The child in care must be told he or she is about to be searched;

(D) The child in care must be asked to remove all outer clothing (gloves, coat, hat, and shoes) and empty all pockets;

(E) The staff member must then pat the clothing of the child in care using only enough contact to conduct an appropriate search;

(F) If the staff detects anything unusual, the child in care must be asked to identify the item and appropriate steps must be taken to remove the item for inspection;

(G) If the child in care refuses to comply, the executive director or designee must be notified immediately and be responsible to resolve the matter; and

(H) All searches must be documented in writing.

(b) Strip searches. An outdoor youth program may not perform strip searches.

(c) Body cavity searches. An outdoor youth program may not perform body cavity searches.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0883, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0956
Transportation

(1) Vehicle. Transportation of youth in an outdoor youth program must be in a vehicle that is:

(a) Properly registered;

(b) Covered by insurance for personal injury and liability;

(c) Driven by a person with a valid driver's license for the type of vehicle who complies with all applicable traffic laws while transporting children in care;

(d) Maintained in a safe condition;

(e) Equipped with a red triangle reflector device for use in emergency;

(f) Equipped with a first aid kit; and

(g) Equipped with a fire extinguisher that is properly secured and not readily available to children in care.

(2) Proper seating of children in care and adults. Children in care and adults in an outdoor youth program must ride in a vehicle manufactured seat, properly using the passenger restraint device in accordance with Oregon law when traveling on public roads. An outdoor youth program must take all reasonable steps to assure the safety of children in care and adults traveling in off road vehicles.

(3) Children in care must be accompanied by at least one person who has been trained in non-violent crisis intervention and de-escalation, physical restraints (if applicable), and First Aid/CPR.

(4) Children in care may not be blindfolded or otherwise have their vision obstructed and may not be handcuffed or shackled while being transported by the program or a subcontractor of the program.

(a) If a program recommends to parents or legal guardians a transport company to bring the child in care to the program, this information shall be noted by the program in the child in care's record.

(b) The Program shall inquire of each child in care brought to the program by a transport company whether he or she was blindfolded or shackled during transport to the program and not this in the child in care's record.

(5) Policies. An outdoor youth program shall have and follow written policies that describe the following:

(a) The method of transportation.

(b) The circumstances when transportation is provided.

(c) Policies shall describe how the safety and integrity of the child in care shall be maintained while being transported;

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0846, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0961
Health Services

(1) Required physical examination. Prior to a child in care engaging in an outdoor youth program activity, an outdoor youth program must review and place in the file a physical examination report for the child in care. This information must be shared with the field staff prior to any outdoor youth program activity. The child in care's health history must be provided by a physician prior to admission, and this history plus a new physical examination must be recorded on a form provided by the program, which clearly documents the type and extent of outdoor youth program activity in which the child in care will be engaged. The examination must cover areas required by the Department and, after the appropriate consents are obtained from the child in care or child in care's legal guardian, must be completed by a licensed physician, physician's assistant or nurse practitioner, who signs the form.

(a) In addition to any other areas required by the Department, the examination must include a physical assessment based on the climate, temperature, and altitude the child in care will be participating in given the child in care 's age, weight, sex, physical condition, and recent use of drugs or alcohol, if any. The physician must state in the examination report any restrictions on the child in care engaging in strenuous exercise based on these or any other factors;

(b) If a child in care is currently taking or has been receiving prescribed medication within the past six months, a specific notation must be made on the physical examination form, by the clearing medical professional, which must include clearance for participation in an outdoor, high impact environment and a description of any possible special needs due to use of the medication in the field environment; and

(c) If a child in care is in a risk group for strenuous exercise or extreme conditions due to medical issues, written clearance must be noted on the physical examination form, stating that the child in care may participate in an outdoor youth program activity, which may:

(A) Occur in altitudes over 5,000 feet;

(B) Include strenuous exercise; and

(C) Expose child in care to cold or hot temperatures.

(d) Children in care may not participate in an outdoor youth program activity until all blood work and other laboratory work has been received and reviewed by the physician, and the physician has found that the child in care is qualified to start the program.

(2) Health information availability. An outdoor youth program must copy the health history and physical exam form and authorization to obtain medical care, maintain the original at the base of operations, and field staff must carry the copy in a waterproof container when the youth is away from the base of operations. All medications must be listed, including dose and frequency.

(3) Appropriate health care. An outdoor youth program must ensure — through staff assignments, training, and program providers — that injuries, illness, or physical complaints by children in care will be promptly and accurately assessed; and that appropriate care is provided.

(4) Prompt first aid treatment. An outdoor youth program must provide first aid treatment in as prompt a manner as the location and circumstances allow.

(5) First aid. An outdoor youth program must have a first aid kit with sufficient supplies available at all times. The first aid kit must;

(a) Meet the standards of an appropriate national organization for the activity being conducted and the location and environment being used;

(b) Be reviewed with new staff for contents and use;

(c) Be reviewed at least annually with all staff for contents and use; and

(d) Be inventoried after each expedition and restocked as needed.

(6) Field treatment. An outdoor youth program must immediately transport to appropriate medical care any child in care with an illness or physical complaint needing care or treatment beyond what can be provided in the field.

(7) Documentation of reports and treatment. An outdoor youth program must document complaints or reports by a child in care of illness and injuries in a daily log along with any treatment provided.

(8) Negative consequences. An outdoor youth program may impose no negative consequence on a child in care for reporting an injury or illness or for requesting to see a health care professional.

(9) Daily physical assessment. Field staff for an outdoor youth program must monitor and document child in care's hydration, skin condition, extremities, and general physical condition on a daily basis.

(10) Weekly physical assessment. A Wilderness First Responder (WFR) or equivalent, an Emergency Medical Technician (EMT), or qualified medical professional must assess each child in care's physical condition in an outdoor youth program at least every seven days. The assessment must be documented and shall at a minimum include:

(a) Heart rate;

(b) Check of extremities;

(c) Condition of skin;

(d) Allergies if any;

(e) General physical condition;

(f) Any health issues specific to the individual child in care; and

(g) Provision of appropriate medical treatment if needed.

(11) Medication storage and administration policies and procedures. An outdoor youth program must have and follow policies and procedures on the storage and administration of prescription and non-prescription medication. The policies and procedures must include contingency planning in the case of medications being lost or destroyed in the field.

(12) Medication storage. An outdoor youth program must store prescription and over-the-counter medication under lock and key safeguarded

from children in care. For medications taken in the field, medication must be in the possession of a staff member and stored at required temperatures.

(13) Documentation of medications. Prescription medication in an outdoor youth program must be issued by a qualified medical professional's valid order that includes the dosage to be given. Senior field staff must administer all medication. Administration of medication must be documented and include:

(a) The name of the child in care;

(b) The name of the medication;

(c) The date and time;

(d) The amount of dosage given and whether the child in care did not take the medication; and

(e) The person who administered or assisted in self-administration of the medication.

(14) Medication changes. An outdoor youth program may not stop or change dosage or administration of prescribed medication nor discontinue any prescription without consulting with a qualified medical professional and documenting the consultation and the change.

(15) Disposal of unused medication.

(a) For purposes of this rule, "unused medication" means any medication which has not been used for 60 days, or a medication held by the facility which has been prescribed for a child in care who has been released from the facility.

(b) For purposes of this rule, "expired medication" means any medication whose designated period of potency, as indicated on the label, has expired.

(c) An outdoor youth program must return all unused or expired medication to the base of operations and dispose of it so it is not available to children in care. A field director or senior field staff must witness and document the disposal of the unused medication.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0815, 413-210-0839, 413-210-0862, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0966
Staff Qualifications and Requirements

(1) Staff written policy requirements. An outdoor youth program must have written policy regarding minimum staff requirements.

(2) Verification. An outdoor youth program must verify qualifications of staff through documentation of minimum requirements for work experience, education, and classroom instruction.

(3) Required staff positions.

(a) An outdoor youth program which provides outdoor youth programming as its primary function must have an executive director. The executive director may also function as the field director if the executive director meets those qualifications. In addition to meeting the requirements in OAR 413-215-0021(3)—(4), the executive director must comply with all of the following:

(A) Be at least 25 years of age.

(B) Have one of the following qualifications at time of hire:

(i) Five years of paid full time experience in the social services or wilderness field with at least one year in a paid administrative capacity.

(ii) A Bachelor's degree and four years of paid full time experience in the social services or wilderness field with at least one year in a paid administrative capacity.

(iii) A Master's degree and three years of paid full time experience in the social services or wilderness field with at least one year in a paid administrative capacity.

(C) Have knowledge and experience demonstrating competence in the performance or oversight of the following essential job functions: program planning and budgeting, fiscal management, supervision of staff, personnel management, employee performance assessment, data collection, reporting, program evaluation, quality assurance, and developing and maintaining community resources.

(D) Demonstrate by his or her conduct the competencies required by this rule and compliance with the program policies and procedures implementing these rules.

(E) Have completed the field training as required by OAR 413-215-0981(3).

(b) Field director. An outdoor youth program must have a field director who is primarily responsible for the quality of each outdoor youth program activity, coordinates field operation, supervises direct care staff, and manages the field office. The field director must:

(A) Be at least 25 years of age;

(B) Have a minimum of 30 college level semester hours or 45 quarter hours in recreational therapy or in a related field or one year of outdoor youth program field experience;

(C) Demonstrate knowledge and understanding of applicable licensing rules;

(D) Have completed the field training as required by OAR 413-215-0981(3);

(E) Hold a Wilderness First Responder (WFR) certificate or equivalent; and

(F) Have completed an approved course in nonviolent crisis intervention.

(c) Senior field staff. An outdoor youth program must have a senior field staff working directly with each group of children in care. Senior field staff must:

(A) Be at least 21 years of age;

(B) Have an associate degree or high school diploma or equivalent with 30 college level semester hours or 45 quarter hours of study or comparable experience and training in a field related to recreation and outdoor youth program activity;

(C) Have a minimum of forty 24-hour field days of program experience or equivalent experience in outdoor programs documented in the personnel file;

(D) Have completed the field training as required by OAR 413-215-0981(3);

(E) Hold a Wilderness First Responder (WFR) certificate or equivalent; and

(F) Have completed an approved course in nonviolent crisis intervention.

(d) Field staff. Each field staff member of an outdoor youth program must:

(A) Be at least 21 years of age;

(B) Have a high school diploma, or its equivalent, or comparable experience directly relevant to assigned outdoor youth program responsibilities;

(C) Have completed the field training as required by OAR 413-215-0981(3); and

(D) Be certified to provide cardiopulmonary resuscitation (CPR) and first aid.

(4) Specific Outdoor Youth Program activity training. All staff of an outdoor youth program must have documented training and experience in conducting any outdoor youth program activity he or she is assigned to conduct.

(5) Multidisciplinary team. An outdoor youth program must have a multidisciplinary team of staff or consultants who have knowledge of the physical and emotional demands of the program and are available to children in care and staff upon the recommendation of the field director or senior field staff. The multidisciplinary team must also be available to outdoor youth program staff upon request for consultation regarding the appropriateness of admission of a child in care. At a minimum, the team must consist of:

(a) A licensed health care professional (physician, doctor of osteopathy, nurse practitioner, or physician's assistant);

(b) A treatment professional who is a licensed or certified psychologist, clinical social worker, marriage and family counselor, or professional counselor; and

(c) If the program does not exclude children in care with substance abuse problems, the multidisciplinary team must include a professional who is a Certified Alcohol Drug Counselor or who has demonstrated equivalent experience and training in the field of alcohol and drug abuse counseling.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; CWP 1-2004, f. & cert. ef. 1-9-04; Renumbered from 413-210-0821, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0971
Staff Health Requirements

An outdoor youth program must comply with all of the following requirements:

(1) Staff health requirements. The outdoor youth program staff members having responsibility for children in care must be free of infectious diseases and must be capable of competently fulfilling all responsibilities reasonably associated with their employment.

(2) Health history questionnaire. As part of orientation, and annually thereafter, staff must complete a health history questionnaire similar to that completed by the children in care entering the program. It must include

injuries or ailments that might affect the ability to function well in the field, or put other field staff or children in care at risk of injury or infection.

(3) Health history questionnaire content. The health history questionnaire must include but not be limited to the following content areas:

(a) Standard physical health questions, including history of infectious diseases;

(b) History of physical injuries; and

(c) History of drug or alcohol abuse or dependence that required residential or outpatient treatment, or that might currently interfere with employment responsibilities.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0824, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0976
Physical Activity Limits and Requirements

An outdoor youth program must comply with all of the following requirements:

(1) Physical capability. Physical activity may not exceed the physical capability of a child in care. Field staff must monitor the physical capability and condition of each child in care to ensure that the outdoor youth program activity does not exceed the child in care's capability.

(a) The program may not assign extremely strenuous exercise at any time.

(b) A child in care when hiking may not carry a backpack and other equipment which exceeds their physical abilities.

(c) Staff shall assist children in care in ensuring that backpacks are packed in a manner that allows them to be comfortably worn.

(d) Children in care shall have breaks prior to becoming weary to avoid risk of injury. Breaks shall be frequent and long enough to recover and return to the outdoor youth program activity.

(e) All children in care in a group shall hike at the speed at which the slowest child in care is capable.

(2) Environmental conditions. Staff of the outdoor youth program must consider environmental conditions including but not limited to temperature, humidity, and precipitation, when planning an outdoor youth program activity so as to minimize the risk of harm (such as heatstroke, frostbite, and hypothermia) to participants.

(3) Acclimation to environment. Staff must closely monitor children in care for acclimation to the elevation and temperature of the environment for the first 72 hours of each child in care's stay in the program to ensure safe assessment of fitness.

(a) Staff must monitor and document each child in care's physical assessment at least three times per day, and more often if the youth is exhibiting signs of exhaustion or fatigue. Youth physical assessment must meet the same criteria as described in OAR 413-215-0961(10).

(b) Staff shall assess each child in care's level of overall fitness, and readiness mentally and physically to engage in more demanding exercise during this time period.

(4) Log. There must be a common daily log, which is signed and dated by the participating senior staff daily. The log must:

(a) Contain information on health problems, accidents, injuries, illnesses, medications used, behavioral problems, and unusual occurrences; and

(b) Include notation of environmental factors such as weather, temperature, and terrain.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0858, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0981
Staff Training

An outdoor youth program must comply with all of the following requirements:

(1) Written policies, procedures, and training curriculum. An outdoor youth program must have written policies, procedures, and training curriculum regarding minimum requirements for orientation, field training, and ongoing training.

(2) Orientation. Each employee must complete orientation before having any contact with children in care or prospective children in care. The orientation training must include at a minimum:

(a) Outdoor youth program mission and goals, including admissions criteria and services provided.

(b) Personnel structure of the outdoor youth program, including an organizational chart and job descriptions which accurately reflect the responsibilities of staff positions involved in the care and management of children in care, and the management and supervision of field staff;

(c) Overview of the quality improvement program, including the critical incident program;

(d) Risk management procedures and safety precautions;

(e) Instruction in discipline and behavior management policies and procedures of the outdoor youth program, including de-escalation and the use of physical restraint, if applicable;

(f) Instruction in physical assist policies and procedures of the outdoor youth program;

(g) Review and discussion of all other policies relevant to field staff responsibilities, such as clothing, nutrition, vehicle use, communication methods, cooking and camping equipment, and their use; and

(h) Emergency plan.

(3) Field training. Each field staff must receive a minimum of seven days of field training and must be assessed by the field director or designee for each of the following minimum required field skills before assuming sole supervision of children in care:

(a) Water, food, and shelter procurement, preparation, and conservation.

(b) "Leave No Trace Principles" for outdoor youth program activity. For purposes of this rule, "Leave No Trace Principles" mean wilderness and land use ethics which are designed to minimize the impact of visitors to back country areas. The principles include: Plan Ahead and Prepare, Travel and Camp on Durable Surfaces; Pack it in, Pack it Out; Properly Dispose What You Can't Pack Out; Leave What You Find; and Minimize Use and Impact of Fire.

(c) Recognition and management of the presenting issues of the children in care served, including mental health and substance abuse issues.

(d) Instruction in safety procedures and safe use of fuel, fire, and life protection equipment.

(e) Sanitation procedures related to food, water, and waste.

(f) Special instruction to ensure proficiency in each specific outdoor youth program activity for staff who conduct and staff who supervise an outdoor youth program activity.

(g) Wilderness medicine, including health issues related but not limited to:

(A) Acclimation.

(B) Exposure to the environment and environmental elements.

(C) Signs, symptoms, and treatment of water intoxication and dehydration.

(D) Foot blisters.

(E) Diarrhea.

(F) Recognizing differences between symptoms of a health concern and behavioral issues.

(G) Bites and Stings.

(H) Allergic reactions.

(I) Gender specific health issues.

(h) First aid kit contents and use.

(i) Basic navigation skills including understanding of contour maps, use of compass, and navigation using the positions of sun, moon, and stars to determine direction.

(j) Local environmental precautions, including terrain, weather, insects, poisonous plants, wildlife, and proper response to adverse situations.

(k) Critical incident prevention, identification, and response.

(l) Knowledge of and ability to implement the emergency plan of the outdoor youth program.

(m) Report writing, including development and maintenance of logs, journals, and incident reports.

(n) Other skills as required by the outdoor youth program.

(4) Sole supervision. No staff member of an outdoor youth program may provide sole supervision of program children in care prior to:

(a) Successful completion of orientation and field training; and

(b) Documented assessment by a senior field staff member of:

(A) Effective understanding of the supervision structure of the outdoor youth program, who is responsible, and to whom staff can refer questions or problems; and

(B) Understanding, knowledge, and compliance with the behavior management policies of the outdoor youth program.

(5) Ongoing training. An outdoor youth program must provide ongoing training for field staff to maintain and upgrade their skills.

(6) Documentation of training. An outdoor youth program must document the training received by each staff member and volunteer in their personnel file. For each training session, the documentation shall include

the name and qualifications of the person providing the training, date of training, training content, and the number of hours of the training.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0830, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0986
Staff Ratios

An outdoor youth program must comply with all of the following requirements:

(1) Staff ratio policy. The outdoor youth program must have written policy and maintain documentation of program compliance on staff ratios.

(2) Group size. For a field group, the number of participants may not exceed twelve children in care.

(3) Staffing ratio. Each group of two or more children in care must be staffed as follows:

(a) By at least two staff members, one of whom must be a senior field staff member;

(b) There must be at least one staff member to every three youth;

(c) Where the gender of a group of children in care is mixed, there must be at least one female staff and one male staff member;

(d) There must be a minimum of five years difference in age between a direct care staff member and the child in care for whom the staff member has sole supervision; and

(e) Volunteers and interns may not be included in the staff ratio unless they meet the qualifications required of staff.

(4) Wilderness first responder (WFR). At least one staff member per group of children in care must have a current Wilderness First Responder (WFR) Certificate or equivalent.

(5) Nonviolent crisis intervention training. At least one staff per group of children in care must be trained in nonviolent crisis intervention.

(6) Field staff training.

(a) There may not at any time be more than one staff member who has not completed all field training.

(b) Where there are four or more children in care, at least two staff members must have completed all field training.

(7) Stationary Outdoor Youth Program staffing ratios.

(a) There must be at least one staff member to every three children in care while a stationary outdoor youth program is engaging in an outdoor youth program activity, whether at or away from the stationary camp.

(b) A stationary outdoor youth program when not engaged in an outdoor youth program activity at the stationary camp is exempt from the one staff member to every three children in care staffing ratio. Staff ratios must be established to provide supervision and protection for children in care and must be adequate in relationship to the type of program, location of program, age and type of children in care served, physical plant design, location and ability of supervisor to respond, backup systems, or any other means to assure a high standard of supervision and protection:

(A) There must be at least one staff member to every ten children in care during the time children in care are awake and present in the program.

(B) There must be at least one staff member on duty to every fourteen children in care during sleeping hours. If staff is sleeping, there must be at least one staff member on duty to every seven children in care during sleeping hours.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0827, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0991
Age Grouping

An outdoor youth program must comply with all of the following requirements:

(1) Minimum Age. A child in care in the outdoor youth program must be at least ten years of age.

(2) Grouping. The outdoor youth program must have policy and documentation regarding age grouping. An outdoor youth program may place children in care in groups only after taking into consideration these factors: the age, developmental level, physical maturity, social maturity, behavioral functioning, cognitive level, diagnosis (if any), and individual needs of each youth.

(3) Placement of youth age 10 years through 12 years. An outdoor youth program may place children in care ten years of age through twelve years of age only in a program component designed for this age group, unless the outdoor youth program has been granted an exception by the Department licensing coordinator.

(4) Placement with adults. If the outdoor youth program serves children in care age 18 years of age or older, it may place children in care under the age of 18 in the same group with children in care age 18 and older only after taking special care to assess and minimize the risk to children in care under the age of 18.

(5) Placement decisions. An outdoor youth program must make placements of children in care in groups to maximize each child in care's functioning and minimize the possibility of exploitation. In making the placement decision in section (4) of this rule or in deciding to request an exception to place a child in care age ten years of age through twelve years of age in an older group, an assigned staff member with documented experience placing youth in groups and who is familiar with the outdoor youth program must:

(a) Base the placement on the factors listed in section (2) of this rule;

(b) Document the basis for the decision and the appropriateness of the placement in the child in care's service plan; and

(c) Review the therapeutic appropriateness of the decision every week after the placement, document whether the decision remains appropriate, and make any changes indicated.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0818, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0992
Referral and Initial Evaluation of Youth

(1) Affirmative duty to gather sufficient information. An outdoor youth program has an affirmative duty to make reasonable efforts to gather sufficient information to determine the appropriateness of the child in care for the outdoor youth program.

(2) Referral. An outdoor youth program must have a policy that addresses the process by which children in care are referred to the outdoor youth program. The policy must include all of the following:

(a) From whom referrals are accepted and whether the program has any type of relationship with the source of referral, including payment for any services provided by the source of the referral to the program.

(b) On what basis children in care are accepted by the outdoor youth program.

(c) How information necessary to provide for the safety and care of children in care will be provided to the appropriate care staff.

(3) Exclusionary policy.

(a) An outdoor youth program must have a written policy that describes any exclusionary criteria for the program.

(b) The outdoor youth program must exclude or have a written policy and must document in the child in care's service plan describing how the program will provide safe and effective treatment specific to each of the following:

(A) Children in care with current risk of fire setting behaviors.

(B) Children in care with active psychosis.

(C) Children in care with current risk of suicide.

(D) Children in care with current risk of harm to self or others.

(E) Children in care with any significant mental health diagnosis.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-0996
Program Services

(1) Admissions assessments. An outdoor youth program must perform an admission assessment on each child in care.

(a) Admissions process. An assigned staff member with documented experience in the area of admissions screening and assessment, who is familiar with the outdoor youth program, must complete an individual admissions assessment for each child in care prior to enrollment.

(b) Admissions to be based on admissions assessment. The outdoor youth program must base admission of each child in care on the individual admissions assessment. The assessment must be the basis for the child in care's service plan. The assessment must include all of the following components:

(A) Social history including home, community, and environment.

(B) Health history, including current prescriptions and over the counter medication;

(C) Psychological history, including behavior problems, aggression, substance abuse, family dynamics, prior evaluations, and any previous treatment.

(D) For a child in care with indications of a mental health diagnosis, the assessment must include a determination by a licensed, certified, or registered mental health professional whether the outdoor youth program is appropriate and how the program activities will address the child in care's needs, or whether another type of mental health treatment is indicated for the child in care before the child in care enters the field portion of the outdoor youth program.

(i) If the program has reasonable grounds to believe that a child in care for whom admission is sought has a mental health diagnosis, the program must require the submission of an evaluation, completed not more than 90 days previously, of the child in care's mental health condition by a clinical psychologist of psychiatrist.

(ii) The evaluation described in subparagraph (i) of this paragraph and other available evaluations and relevant documentation must be reviewed by a qualified mental health professional who must describe in writing how the treatment to be provided at the outdoor youth program is appropriate for the identified mental health diagnosis. This description must include how the activities of the program will address the needs of the child in care and relate to the child in care's service plan.

(E) For a child in care with indications of substance abuse, the assessment must include a determination by a professional in chemical dependency whether detoxification is indicated for the child in care before the child in care enters the field portion of the outdoor youth program.

(c) Consultation and additional information. If after a review of the components required by the Admissions Assessment, there is any question as to the appropriateness of admission of a child in care, the assigned staff member must consult with the Multidisciplinary Team and document the decision. If the information available about the child in care is inadequate for the determination of appropriateness for the outdoor youth program, the outdoor youth program must require additional necessary information which may include evaluations by consulting professionals.

(d) Evaluation of appropriateness of admission. Each admissions assessment must include a summary evaluation of the appropriateness of the admission of the child in care into the outdoor youth program.

(e) Field entry.

(A) An outdoor youth program must conduct an interview and orientation with each child in care before the child in care leaves for the field portion of the program away from the main base of operations.

(B) The field director or senior field staff assigned to the child in care's field experience must conduct an interview with the child in care prior to entrance into the field; and

(C) The medically trained field staff assigned to the child in care's field experience must conduct a review of the child in care's health history and physical examination report.

(2) Service planning. Each child in care must be served according to a service plan, developed by the outdoor youth program staff and including, whenever possible, the program director, child-care workers, other involved professionals, the child in care, and his or her family. The program must make every effort to secure the participation of the legal guardians in planning, and, if they do not participate, must document the reasons why. An outdoor youth program has an affirmative responsibility to provide competent individualized service planning for each child in care to include ongoing evaluation and change as needed. Service planning time lines must be as follows:

(a) Initial service plan. An outdoor youth program must write the initial service plan based on the admission assessments, all referral documents, and the child in care's individual needs on or before admission, and provide a copy to the senior field staff upon the child in care's entry into the outdoor youth program.

(b) Updated service plan. Within 14 days of the date the child in care enters the field, the outdoor youth program must write an updated service plan based on field observations and additional information received (family information, medical reports, and child in care disclosures). If a child in care has a significant mental health diagnosis, the service plan must specify how and by whom the treatment related to the diagnosis will be addressed.

(c) Monthly review. The outdoor youth program must review and update the service plan monthly, and document the review. Changes in the service plan must be promptly shared with the child in care and the child in care's legal guardian.

(d) Discharge summary. The discharge summary must include a written summary of the child in care's participation and progress achieved, results of evaluations, conditions of the child in care, interactions of child in care and staff, briefings and debriefings, compliance with program policies and procedures, and recommendations. The discharge summary must be retained in the child in care's file and a copy provided to the child in care's legal guardians.

(3) Areas of emphasis in the service plan and planning process. It is the intent of the Department that an outdoor youth program must make every reasonable effort to ensure participation by the child in care's family in all aspects of the service and service planning process. To that end, the outdoor youth program staff must:

(a) Encourage parent participation in the intake process;

(b) If the child in care's parent or legal guardian cannot participate in the intake process, ensure participation in the intake process by those responsible for the environment in which the child in care resides prior to placement with the outdoor youth program;

(c) Support the family and those responsible for the environment in which the child in care resides during intervention activities, including alternate suggestions for any child in care not accepted at intake;

(d) Consider the family's responsibility, needs, and values in the planning and service process;

(e) Provide an orientation procedure for the child in care and his or her family;

(f) Ensure that information regarding significant events in the child in care's family is passed on to appropriate staff members;

(g) Review service plans, activities, and progress with the family monthly; and

(h) Ensure that the educational needs of the child in care are an integral part of the service plan. Children in care who have not graduated from high school must have access to an appropriate education that affords sufficient transferable credits for the child in care to stay on course to graduate.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0812, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-1001
Critical Incident Program

(1) Quality improvement program. An outdoor youth program must have a written quality improvement program which identifies and defines critical incidents, includes a response to each type of critical incident, and includes procedures for the review of critical incidents.

(2) Critical incident training. An outdoor youth program must train staff in critical incident prevention, identification, and response.

(3) Documentation of critical incidents. The outdoor youth program staff must document each critical incident as follows:

(a) Record each incident in the common daily log and complete an incident report immediately following the incident;

(b) Categorize each incident as to type and seriousness;

(c) Record the results of staff debriefing of each critical incident; and

(d) Management must document review of each critical incident report within 24 hours of receipt.

(4) Review of critical incidents. An outdoor youth program must have procedures for review of critical incidents which include management and board review of critical incidents and a process for deciding if revisions to program policy and procedures, operations, or training are warranted for quality improvement.

(5) Documentation of critical incident review. An outdoor youth program must document in writing the process and results of its review of critical incidents and resulting program quality improvements if any and must provide this information to staff.

(6) Near miss. An outdoor youth program must review any near miss and determine whether to respond to it as if it were a critical incident in accordance with this rule. For purposes of this rule, "near miss" means:

(a) A close call;

(b) A potentially dangerous situation where safety was compromised but that did not result in injury; or

(c) An unplanned and unforeseen event after which those involved express relief that the incident ended without harm.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0860, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-1006
Field Outdoor Youth Program Activities

An outdoor youth program must comply with all of the following requirements:

(1) Written description. There must be a written description of each field outdoor youth program activity and a schedule, including a detailed itinerary.

(2) Staff briefing. The executive director, field director, or designee must brief staff entering the field. The briefing at a minimum must include:

(a) The planned route, terrain, time schedule, weather forecast, and any potential hazards;

(b) Any procedures unique to that field experience; and

(c) The background of the child in care and any potential problems.

(3) Itinerary. Field staff must carry map routes, anticipated schedules, and times when a group is in the field.

(4) Supervision. The field director or designee must conduct and document supervisory evaluation of each youth and staff in a field group at least every seven days, either in person or through Department approved procedures. If the planned itinerary is longer in duration than three weeks, the field director or designee must make onsite visits at minimum increments of three weeks.

(5) Staff debriefing. The field director or designee must debrief staff after they return from the field.

(a) An outdoor youth program must document the debriefing of staff (whether individual or group) received by each staff member in his or her personnel file.

(b) For each debriefing session, the documentation must include the name and qualifications of the person providing the debriefing, the date of the debriefing, any performance issues, and the length of time of the session.

(6) Child in care debriefing. The field director or designee must debrief a child in care after returning from the field. The debriefing must at a minimum:

(a) Include a written summary of the child in care's participation and progress achieved;

(b) Be provided in written form to the child in care's parents or guardian; and

(c) Legal guardians and child in care must be given the opportunity and encouraged to submit a written evaluation of the outdoor youth experience, to be maintained by the outdoor youth program.

(7) Documentation. An outdoor youth program must document results of the evaluation of the conditions of the child in care, interactions of child in care and staff, briefings, debriefings, and compliance with program policies and procedures, and include them in the child in care's record and discharge summary.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0833, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-1011
Communication

(1) For purposes of this rule, a "Global Positioning System receiver" means a receiver which receives signals from a network of 24 satellites known as the Global Positioning System (GPS) and identifies the receiver's location: latitude, longitude, and altitude to within a few hundred feet.

(2) Communication and support system. An outdoor youth program must maintain a communication system that includes the use of Global Positioning System receivers, two way radio communication, and cell phone communication; or follows the applicable land managing agency requirement and includes:

(a) Reliable communication between each group and the base of operations; and

(b) A back up plan for re-establishing communication to be implemented in the event regular communication fails.

(3) Communication requirements. An outdoor youth program must have a reasonable communication plan which is sufficient to provide routine and emergency care and takes into consideration individual child in care needs and terrain considerations.

(a) There must be oral communication between each field group and the base of operations on a regularly scheduled basis according to program procedures, unless special documented arrangements have been made;

(b) In no case may the absence of oral communication between a field group of children in care and the base of operations exceed 72 hours, unless the Department has approved an exception for alternate program procedures for communication; and

(c) In no case may a field group of children in care be more than one hour away from the ability to make contact with emergency services.

(4) Emergencies. The base of operations support personnel for an outdoor youth program must have immediate access to emergency telephone numbers, contact personnel, and procedures for an emergency evacuation or critical incident requiring emergency medical support.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0836, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-1016
Work

In compliance with child labor laws, an outdoor youth program may as a constructive experience give children in care non-vocational work assignments, which are age appropriate and within the youth's capabilities. The primary purpose of work may not be to substitute for paid labor for the benefit of the outdoor youth program, nor may it be to discipline the child in care.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0841, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-1021
Animals and Pets

An outdoor youth program must comply with all of the following requirements:

(1) Animals and pets must be free from disease and cared for in a safe and clean manner.

(2) An outdoor youth program must take reasonable measures to assure that children in care are not exposed to danger from animals.

(3) All domestic animals and pets must be vaccinated against rabies. Documentation of the vaccination against rabies must be available in the responsible employee's personnel file.

Stat. Auth.: ORS 418.005, OL 2016, ch 10
Stats. Implemented: ORS 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0843, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-1026
Solo Experiences in Outdoor Youth Programs

If an outdoor youth program conducts individual or separate components for child in care (solo experiences) as part of the therapeutic process, the program must have and follow written policies and procedures. The policies and procedures at a minimum must require all of the following:

(1) Individual solo plan. Each child in care participating in a solo experience must have a plan which includes goals, methods, techniques, time frames, and takes into consideration the maturity, health, and physical ability of the child in care.

(a) The child in care must be instructed on the solo experience and individual plan including expectations, restrictions, communication, environment, and emergency procedures;

(b) Each child in care must have and receive instruction on a back-up plan in case the primary plan does not work; and

(c) A designated staff member must be responsible for coordination and implementation of the plan.

(2) Environmental requirement. Staff must be familiar with the site chosen to conduct solo experiences and must pre-investigate the site to ensure the terrain is appropriate for the skill level of the child in care and that hazardous conditions are considered. Staff must make arrangements for medication, food, and water drops if needed.

(3) Supervision. Plans for supervision must be in place during the solo experience, including the assignment of a staff member responsible for the supervision of the child in care, and procedures for placement, supervision, and observation of the child in care. Supervision must include communication systems, visual checks, and regular checks of the child in care's emotional and physical condition.

(4) Emergency procedures. In addition to the requirements of the Emergency Plan section of these rules (OAR 413-215-0936), solo emergency plans must include but are not limited to: instructing the child in care on the safety and emergency procedures, establishing an effective system for emergency communication available at all times, instruction of other children in care on how to respond if the emergency notification system is put into use, and a check-in system should an emergency occur.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0849, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

413-215-1031
Behavior Management

An outdoor youth program must comply with all of the following requirements:

(1) If a child in care refuses or is unable to hike, a contingency plan must be developed based on Department approved policies and procedures. The contingency plan must ensure that if the group of children in care is split, there is proper staff coverage for each group of children in care, and communication between the groups of children in care is maintained.

(2) Physical assist.

(a) "Physical assist" means action by staff members to physically aid, support, or redirect children in care who are not resisting. A physical assist includes staff leading children in care along the trail, moving the child in care to his or her campsite by gently pulling on a backpack strap, guiding him or her by the hand or elbow, or placing a hand on the child in care's back. The child in care may not want to be physically assisted but he or she does not offer resistance.

(b) Appropriate use of a physical assist occurs when staff members physically aid, support, or redirect children in care who are not physically resisting. If a child in care resists reasonable staff direction, staff must assess whether the use of physical restraint is warranted based on the written nonviolent physical restraint policy of the outdoor youth program. An intervention becomes a physical restraint when the child in care resists, has "dug in his or her heels", and is propelled or held still against that resistance. Staff members must comply with all applicable physical restraint regulations, including OAR 413-215-0076.

(3) Time out.

(a) For purposes of this rule, "time out" means imposed separation of a child in care from any group activity or contact as a means of behavior management.

(b) An outdoor youth program may use time out only when a child in care's behavior is disruptive to the child in care's ability to learn, to participate appropriately, or to function appropriately with other child in care or the activity.

(c) The outdoor youth program must designate a staff member to be responsible for visually observing the child in care at random intervals at least every fifteen minutes.

(d) If the duration of a time out exceeds one hour, or there is visual separation of the child in care, the outdoor youth program must write an incident report in sufficient detail to provide a clear understanding of the incident or behavior which resulted in the child in care being placed in time out, and staff's attempts to help the child in care avoid time out. The child in care's legal guardians must be provided with a copy of the documentation of each time out under this subsection within 72 hours.

(e) The outdoor youth program must reintroduce a child in care to the group in a sensitive and non-punitive manner as soon as control is regained.

(f) If there are timeouts equaling more than 3 hours within a 24 hour period, the executive director or designee must conduct a review to determine the suitability of the child in care remaining in the outdoor youth program, whether modifications to the child in care's plan are warranted, and whether staff need additional training in alternative therapeutic behavior management techniques. The outdoor youth program must take appropriate action as a result of the review.

(g) Time outs may be assigned by staff or self-imposed.

(h) Children in care may not be physically restrained because the youth leaves an assigned time-out.

Stat. Auth.: ORS 409.050, 418.005, 418.240, OL 2016, ch 10
Stats. Implemented: ORS 409.010, 418.205 - 418.325, 418.990 - 418.998, OL 2016, ch 10
Hist.: SOSCF 9-2002, f. & cert. ef. 5-29-02; Renumbered from 413-210-0872, CWP 28-2008, f. & cert. ef. 10-17-08; CWP 7-2013, f. & cert. ef. 10-1-13; CWP 12-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

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Department of Human Services, Self-Sufficiency Programs
Chapter 461

Rule Caption: Amending rules relating to public assistance programs
Adm. Order No.: SSP 23-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 7-1-16
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Rules Adopted: 461-180-0135
Rules Amended: 461-130-0327, 461-130-0330, 461-130-0335, 461-135-0089, 461-135-0400, 461-135-0521, 461-145-0360, 461-155-0150, 461-160-0010, 461-160-0015, 461-160-0410, 461-165-0010, 461-165-0180, 461-175-0200, 461-175-0220, 461-190-0211, 461-190-0231, 461-193-0320, 461-195-0501
Rules Repealed: 461-135-0521(T), 461-160-0410(T), 461-165-0180(T), 461-180-0135(T), 461-193-0010, 461-193-0890, 461-193-0940, 461-193-0960, 461-193-1230
Subject: OAR 461-130-0327 about good cause criteria for failure to comply with a program requirement is being amended to state that in the REF program, a client may have good cause for quitting a job if the client has to travel an "unreasonable distance" or if the hours or nature of the job interferes with a client's religious observances, convictions, or beliefs. This criteria was previously addressed in OAR 461-193-0890 which stated the good cause criteria for New Arrival Employment Services (NAES) and Refugee Case Services Project (RCSP). That rule is being repealed.

OAR 461-130-0330 about disqualifications is being amended to change the reduction schedule for TANF clients being sanctioned for non-cooperation in the Job Opportunity and Basic Skills program. The new reduction schedule will be four levels (instead of two) of progressive percentage reduction in the family's TANF grant: 25 percent for the first level, 50 for the second, 75 for the third, and 100 for the fourth. Clients may remove the disqualification by contacting the Department to re-engage on or before the end of the fourth level as provided in OAR 461-130-0335. This rule is also amended to separate the re-engagement and progressive disqualification levels for the REF program and align them with 45 CFR 400.82. This was previously addressed in OAR 461-193-0940 about disqualifications for NAES and RCSP. That rule is being repealed.

OAR 461-130-0335 about removing disqualifications and the effect on benefits is being amended to align the requirements for disqualified TANF clients with changes being made to OAR 461-130-0330 described above. This rule is also amended to separate the REF requirements for ending a disqualification and align them with federal requirements. Specifically, a disqualification ends in the REF program when the Department determines the individual is exempt or REF program benefits close for a reason other than because of a disqualification. Ending REF disqualifications was previously addressed in OAR 461-193-1230 about removing disqualifications for NAES and RCSP. That rule is being repealed.

OAR 461-135-0089 about demonstrating compliance with substance abuse and mental health requirements and restoring benefits is being amended to align the requirements for disqualified TANF clients with changes to the progressive disqualification benefit reduction schedule in OAR 461-130-0330 described above. This rule is also amended to remove reference to the REF program; these provisions are not applicable to that program because they do not comply with the federal disqualification requirements in 45 CFR 400.82.

OAR 461-135-0400 about specific requirements for the ERDC program; OAR 461-155-0150 about the child care eligibility standard, payments rates, and copayments; OAR 461-160-0010 about the use of resources in determining eligibility; and OAR 461-160-0015 about resource limits are being amended to implement a resource limit of $1,000,000 for the ERDC program consistent with federal regulations.

OAR 461-135-0521 about job quit for SNAP applicants is being amended to include ABAWD (able-bodied adults without dependents) as clients subject to the rule which states that applicants are not eligible for SNAP benefits if they quit a job or reduced work hours in the 30 days prior to applying for SNAP or at any time while receiving SNAP. This makes permanent a temporary rule adopted on April 1, 2016.

OAR 461-145-0360 about motor vehicles is being amended to clarify how to determine the fair market value of an automobile, truck, or van. Specifically, Kelley Blue Book and similar publications are added as authorities that may be used to determine the "average trade-in value". Previously the rule required eligibility staff to use the NADA (National Automobile Dealers Association) Used Car

Guide first and then if the vehicle was not listed, the Kelley Blue Book would be used, followed by a "similar publication".

OAR 461-160-0410 about treatment of income when there are ineligible or disqualified group members in the SNAP program is being amended to state that if a member in a group is ineligible because of the ABAWD time limits, the income of the ineligible individual is prorated as described in the rule. This makes permanent a temporary rule adopted on April 1, 2016.

OAR 461-165-0010 about the legal status of benefits is being amended to prohibit the use of EBT (Electronic Benefit Transfer) cards at marijuana dispensaries and OAR 461-195-0501 about definitions and categories of overpayments is being amended to state that benefits accessed at a marijuana dispensary is an overpayment.

OAR 461-165-0180 about child care provider eligibility requirements is being amended to clarify that providers are placed in failed status for failure to meet eligibility requirements in the rule that are not covered under the new suspended status and that while in failed status, the Department does not pay providers for child care at the site of a previously failed provider or at another site if a previously failed provider is involved in the child care operation, unless the Department determines that the reasons for the provider's failed status are not relevant to the new site. This make permanent a temporary rule adopted on January 20, 2016. The rule is also amended to create a finding of suspended for child care providers who have failed to meet certain eligibility requirements that cannot be immediately remedied. Providers in suspended status are ineligible for payment for six months but may reapply after six months by submitting information to the Department for review. This makes permanent a temporary rule adopted on March 14, 2016. Lastly, unnecessary references to the Child Care Billing and Attendance Tracking (CCBAT) system are being removed.

OAR 461-175-0200 about general notice requirements and OAR 461-175-0220 about notice requirements for disqualifications are being amended to state that in the SNAP program, the Department sends a notice of termination when an individual signs an IPV (intentional program violation) waiver of hearing rights.

OAR 461-180-0135 about restoring benefits for ABAWD clients is being adopted to allow the Department to restore benefits to ABAWD clients in the month after they reach the time limit without reapplying in certain circumstances. This makes permanent a temporary rule adopted on April 1, 2016.

OAR 461-190-0211 about support services is being amended to make minor language clarifications about when the Department pays for fuel costs for a privately-owned vehicle.

OAR 461-190-0231 about re-engagement is being amended to add that re-engagement includes an opportunity to follow-up on screenings for physical or mental health needs, substance abuse, domestic violence, or learning needs and that in the JOBS program, re-engagement includes an attempted home visit. This rule is also amended to include the REF re-engagement requirements which were previously addressed in OAR 461-193-0960 about re-engagement for NAES and RCSP. That rule is being repealed. Lastly, to avoid confusing the assessment of risk of harm to a child relating to the reduction of TANF benefits with the more formal Child Welfare process described in OAR 413-015-0400 to 413-015-0485, the rule is amended to change "assessment" of risk of harm to a child to "assessing." This is also consistent with the language in ORS 412.009.

OAR 461-193-0010 about client responsibilities for NAES and RCSP is being repealed. This information is addressed in the general client responsibilities rule, OAR 461-105-0020.

OAR 461-193-0320 about the effective date for cash assistance in the Refugee Case Service Project (RCSP) is being amended to state that unless specified otherwise in the rule, the effective date is as provided for REF and TANF clients in OAR 461-180-0070.

In addition, non-substantive edits were made to these rules to: ensure consistent terminology throughout self-sufficiency program rules and policies; make general updates consistent with current Department practices; update statutory and rule references; correct formatting and punctuation; improve ease of reading; and clarify Department rules and processes.

Rules Coordinator: Kris Skaro—(503) 945-6067

461-130-0327
Good Cause

In a Department program administered under OAR 461-130-0305 to 461-130-0335 and 461-135-0085 and 461-135-0089:

(1) The Department does not require a client to provide verification of good cause if providing the verification would expose the client to increased risk of domestic violence (see OAR 461-001-0000).

(2) If in making a determination under this rule a client's physical or mental impairment is in question, the Department may require the client to provide documentation from a qualified and appropriate medical professional.

(3) A client is excused for good cause from a failure to comply with a program requirement, including an activity in a case plan (both terms defined in OAR 461-001-0025) in the following circumstances:

(a) Participation in a required activity in a case plan would have an adverse effect on or risk to the client's physical or mental health or would expose the client to increased risk of domestic violence (see OAR 461-001-0000).

(b) Except in the SNAP program, participation is likely to cause undue hardship for the dependent child (see OAR 461-001-0000) or the client.

(c) Appropriate child care, or day care for an individual in the household who has a disability (see OAR 461-001-0000 and 461-001-0015 as applicable) that substantially reduces or eliminates the individual's ability to care for himself or herself, cannot be obtained. "Appropriate child care" means that:

(A) Both the provider and the place where care is provided meet health, safety, and provider requirements as required in OAR 461-165-0180;

(B) The care accommodates the parent's work schedule; and

(C) The care meets the specific needs of the dependent child, such as age and special-needs requirements.

(d) The work attachment position or employment offered is vacant due to a strike, lockout, or other labor dispute.

(e) The work attachment position or employment requires the client to join a union, and the client has religious objections to unions.

(f) The client belongs to a union and the employment violates the conditions of the client's membership in the union.

(g) The wage for the client's current or potential job is:

(A) Less than applicable minimum wage; or

(B) If minimum wage laws do not apply, the wage (rate for piece work) is less than that normally paid for similar work.

(h) The client's prospective employer engages in employment practices that are illegally discriminatory on the basis of age, sex, race, religious or political belief, marital status, disability, sexual orientation, or ethnic origin.

(i) The client's participation in a required activity in a case plan would prevent or interfere with the client's participation in an activity of the Grande Ronde Tribe's NEW program.

(j) The client's failure to participate is due to a circumstance beyond his or her reasonable control.

(k) When the failure to comply is caused by an aspect of the client's disability, including the Department's failure to provide a reasonable accommodation.

(l) The client quits a job to accept another job with a monthly income at least equal to the monthly income of the first job.

(m) The Department determines there are no appropriate activities or necessary support services (see OAR 461-001-0025) to support an activity (see OAR 461-001-0025) in order for the client to participate.

(n) In the REF program:

(A) If the client has no means of transportation and would have to walk an unreasonable distance to meet the participation requirement. An "unreasonable distance" is a distance that requires a commute of more than two hours each day; or

(B) If the hours or nature of the job interferes with the client's religious observances, convictions, or beliefs.

(4) In the SNAP program, a client is excused from not accepting employment or for leaving a job under the following circumstances:

(a) The hours or nature of the job interferes with the client's religious observances, convictions, or beliefs.

(b) The client accepts employment or enrolls at least half-time in any recognized school, training program, or institution of higher education that requires the client to quit a job.

(c) A client accepts employment or enrolls in school in another county, requiring the benefit group (see OAR 461-110-0750) to move and the client to quit a job.

(d) A client less than 60 years of age resigns, and the employer recognizes the resignation as retirement.

(e) The client leaves a job to follow a type of employment that moves from one area to another, such as migrant labor or construction.

(f) The client accepts a job that, for reasons beyond the control of the client, does not materialize or results in fewer work hours or a lower wage than the client's previous job.

(g) Work demands or conditions, such as not being paid for work or not being paid on schedule, make employment unreasonable.

(h) The wage for the client's current or potential job is less than applicable minimum wage or, if minimum wage laws do not apply, the wage (rate for piece work) is less than that normally paid for similar work.

(i) The work schedule for the job in question does not conform to hours customary to the occupation or the hours worked each week are more than those customary to the occupation.

(j) The client is not obligated to accept a job during the first 30 days of registration for employment if the job is not in the client's field of experience.

(k) The client has no means of transportation and would have to walk an unreasonable distance to meet the participation requirement. An "unreasonable distance" is a distance that requires a commute of more than two hours each day. The client must make a good-faith effort to secure the needed transportation.

(l) Lack of adequate child care for a child who is six years of age or older and less than 12 years of age.

Stat. Auth.: ORS 409.050, 411.060, 411.816, 412.006, 412.009, 412.049

Stats. Implemented: ORS 409.010, 411.060, 411.117, 411.816, 412.006, 412.009, 412.049

Hist.: AFS 17-1998, f. & cert. ef. 10-1-98; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 11-1999, f. & cert. ef. 10-1-99; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; SSP 17-2004, f. & cert. ef. 7-1-04; 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 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 34-2011, f. 12-27-11, cert. ef. 12-29-11; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-130-0330

Disqualifications; Pre-TANF, REF, SNAP, TANF

(1) In the Pre-TANF, REF, SNAP, and TANF programs, the Department may not disqualify from program benefits a client who is a volunteer (see OAR 461-130-0305 and 461-130-0310) participant in an employment program.

(2) In the Pre-TANF and TANF programs, a mandatory (see OAR 461-130-0305) client who fails to comply with an employment program participation requirement and does not have good cause (see OAR 461-130-0327) for the failure to comply is subject to disqualification under this rule only after the requirements of all of the following subsections are met:

(a) The client has had the opportunity to participate in the re-engagement process under OAR 461-190-0231.

(b) The Department has determined the client is willfully non-compliant and does not have good cause for failing to comply with a requirement of the program.

(c) The Department has offered (and the client has refused) or conducted screenings (and assessed if appropriate) for physical or mental health needs, substance abuse, domestic violence (see OAR 461-001-0000), and learning needs.

(d) The Department has determined the client has no barriers (see OAR 461-001-0025) or refuses to take appropriate steps to address identified barriers.

(e) The Department has determined the client has not met federally required participation rates (see OAR 461-001-0025).

(f) The Department has assessed for any risk of harm posed to the children by a reduction in cash assistance.

(3) In the REF program, a mandatory client who fails to comply with an employment program participation requirement and does not have good cause for failure to comply is subject to disqualification under this rule only after the requirements of all of the following subsections are met:

(a) The client has had the opportunity to participate in the re-engagement process under OAR 461-190-0231.

(b) The Department has determined the client is willfully non-compliant and does not have good cause for failing to comply with a requirement of the program.

(c) The Department has offered available screenings (and the client has refused) or conducted available screenings (and assessed if appropriate) for physical or mental health needs, substance abuse, domestic violence, and learning needs.

(d) The Department has determined the client has no barriers or refuses to take appropriate steps to address identified barriers.

(4) In the REF program, the effects of a disqualification are progressive. There are two levels of disqualification:

(a) At the first level of disqualification, the penalty is the removal of the disqualified client from the need group (see OAR 461-110-0630) for three months. If the disqualified client is the only member of the filing group (see OAR 461-110-0310 and 461-110-0430), the assistance is terminated.

(b) At the second level, the penalty is the removal of the disqualified client from the need group for six months. If the disqualified client is the only member of the filing group, the assistance is terminated.

(5) In the TANF program, the effects of a JOBS disqualification are progressive. There are four levels of disqualification. Once a disqualification is imposed, it affects benefits according to the following schedule until the disqualification ends in accordance with OAR 461-130-0335:

(a) At the first level, the penalty is a 25 percent reduction in benefits.

(b) At the second level, the penalty is a 50 percent reduction in benefits.

(c) At the third level, the penalty is a 75 percent reduction in benefits.

(d) At the fourth level, the penalty is a 100 percent reduction in benefits.

(e) At the end of the fourth level, program benefits are closed and the filing group (see OAR 461-110-0310 and 461-110-0330) may not receive program benefits for the following two consecutive months.

(6) In the SNAP program:

(a) A mandatory client not covered under subsection (b) of this section who fails to comply with the requirements of an employment program without good cause (see OAR 461-130-0327) is subject to disqualification. A disqualified client is removed from the need group until he or she meets the employment program requirements and serves the applicable progressive disqualification under the following subsections:

(A) One calendar month for the first failure to comply.

(B) Three calendar months for the second failure to comply.

(C) Six calendar months for the third and subsequent failures to comply.

(b) A mandatory client who is an ABAWD (see OAR 461-135-0520) residing in Multnomah or Washington County or a mandatory client who is served by an office that does not offer OFSET (see OAR 461-190-0310) who fails to comply with the requirement to maintain employment in OAR 461-130-0315(1)(f)(B) is subject to disqualification as provided in subsection (a) of this section. See OAR 461-135-0520 for additional employment participation requirements for ABAWD clients.

(c) A client who is exempt (see OAR 461-130-0305) from participation in the SNAP employment program because he or she is a mandatory participant in the JOBS program, receiving unemployment compensation benefits, or has applied for unemployment compensation benefits and is waiting on an initial decision must comply with the requirements of those programs. If the client fails to comply with the requirements of the applicable program the client is disqualified from receiving SNAP benefits, unless he or she can show good cause under OAR 461-130-0327.

Stat. Auth.: ORS 411.060, 411.816, 412.009, 412.049

Stats. Implemented: ORS 411.060, 411.816, 411.837, 412.009, 412.049

Hist.: AFS 17-1998, f. & cert. ef. 10-1-98; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; AFS 9-1999, f. & cert. ef. 7-1-99; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 7-2005, f. & cert. ef. 7-1-05; 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 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13: SSP 37-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-130-0335

Removing Disqualifications and Effect on Benefits

(1) An applicant who would be subject to an employment program disqualification under OAR 461-130-0330 but withdraws the application before benefits are approved is not subject to disqualification.

(2) In the REF, SNAP, and TANF programs, a filing group (see OAR 461-110-0330, 461-110-0370, and 461-110-0430) is not subject to the impact of a disqualification for a disqualified member who has left the household group (see OAR 461-110-0210). If the member joins another filing group, that group is subject to the member's most recent disqualification.

(3) In the REF program, a disqualification ends when:

(a) The Department changes the participation classification of the disqualified individual to exempt (see OAR 461-130-0305); or

(b) REF program benefits are closed for a reason other than described in OAR 461-130-0330(4).

(4) In the TANF program, an individual disqualified for failure to meet the requirements of an employment program under division 190 of these rules:

(a) At the first, second, third, and fourth level of disqualification must cooperate for two consecutive weeks with each activity (see OAR 461-001-0025) specified in the individual's current or revised case plan (see OAR 461-001-0025) before the Department may remove the disqualification. Cash benefits are restored effective the date the individual completes the two consecutive week cooperation period.

(b) When the fourth level of disqualification ends, TANF program benefits are closed and the filing group is ineligible for TANF program benefits for two consecutive months, unless the individual contacts a representative of the Department and agrees to each activity specified in the individual's current or revised case plan before the end of the fourth level. If the individual completes the two consecutive weeks of cooperation, cash benefits are restored effective the date the individual completes the two consecutive week cooperation period.

(c) Cash benefits are restored effective the date it is determined, by the Department, there are no appropriate activities or support services (see OAR 461-001-0025) necessary to support the activity available in order for the individual to demonstrate participation.

(5) In the TANF program, a disqualification ends when:

(a) The Department changes the participation classification of the disqualified individual to exempt (see OAR 461-130-0305);

(b) A mandatory (see OAR 461-130-0305) individual in the need group (see OAR 461-110-0630) complies with the requirements of the employment program as provided in section (4) of this rule;

(c) TANF program benefits are closed for a reason other than described in OAR 461-130-0330(5)(e);

(d) The individual is no longer a member of the household group; or

(e) The individual is unable to participate because there is no appropriate activity or support services necessary to support the activity.

(6) In the SNAP program:

(a) The disqualification ends the first day of the month following the month in which information is provided to the Department justifying the change in the individual's participation classification (see OAR 461-130-0310), even if the date falls within the disqualification period provided in OAR 461-130-0330.

(b) A mandatory individual disqualified under OAR 461-130-0330 for failure to meet the requirements of a SNAP employment program must show compliance with the employment and training program for 30 days. The local DHS branch will determine the activities as either work search activities or cooperation with the OFSET contractor.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.816, 412.009, 412.049

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.816, 411.825, 411.837, 412.009, 412.049

Hist.: AFS 17-1998, f. & cert. ef. 10-1-98; 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 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 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; SSP 24-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-135-0089

Demonstrating Compliance with Substance Abuse and Mental Health Requirements; Restoring Cash Benefits; Pre-TANF, TANF

In the Pre-TANF and TANF programs:

(1) In order to end a penalty imposed under OAR 461-135-0085:

(a) At the first, second, third, and fourth level of disqualification (see OAR 461-130-0330), a client must:

(A) Cooperate for a period of two consecutive weeks with each activity (see OAR 461-001-0025) specified in the client's current or revised case plan (see OAR 461-001-0025); and

(B) Demonstrate a willingness to participate in treatment required under OAR 461-135-0085 if treatment is still required.

(b) When the fourth level of disqualification (see OAR 461-130-0330) ends, program benefits are closed for two consecutive months, unless the client:

(A) Contacts a representative of the Department and agrees to each activity in the case plan before the end of the fourth level; and

(B) Demonstrates a willingness to participate in treatment required under OAR 461-135-0085 if treatment is still required.

(2) The penalty imposed under OAR 461-135-0085 ends when:

(a) TANF program benefits are closed for a reason other than described in OAR 461-130-0330(5)(e); or

(b) The individual complies with the requirements of section (1) of this rule.

(3) When the Department removes a disqualification due to a client's compliance with the requirements under OAR 461-135-0085, cash benefits are restored effective the date the client completed the two consecutive week cooperation period.

Stat. Auth.: ORS 411.060, 411.070, 412.006, 412.009, 412.049

Stats. Implemented: ORS 411.060, 411.070, 412.006, 412.009, 412.049, 412.089

Hist.: AFS 27-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; 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 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

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 461-110-0310 and 461-110-0350) must meet the requirements of all of the following subsections:

(a) Except as provided in subsection (c) of this section, every caretaker (see OAR 461-001-0000) in the filing group must receive income from employment. This includes self-employment (see OAR 461-145-0910) and employment through a work study program.

(b) The filing group must include a child (see OAR 461-001-0000) 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, the unemployed 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.

(C) Confirmation is received from the Office of Child Welfare Programs that supervised contact is required between the child and an unemployed parent (see OAR 461-001-0000) or spouse (see OAR 461-001-0000) who is living in the home with the child.

(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.

(f) The filing group must certify that they do not exceed the resource limit in OAR 461-160-0015 and must meet the income limits in 461-155-0150.

(3) A filing group not willing to obtain a Certificate of Immunization Status for the child is not eligible for a child care payment for more than twelve calendar months, or longer if child care continues under OAR 461-160-0040(5).

(4) The child care must be necessary to enable the caretaker to remain employed, including 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 329A.500, 409.050, 411.060, 411.070

Stats. Implemented: ORS 329A.500, 409.010, 409.050, 409.610, 411.060, 411.070, 411.122, 411.141, 418.485

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; SSP 23-2015, f. 9-28-15, cert. ef. 10-1-15; SSP 36-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-135-0521
Job Quit by Applicants; SNAP

(1) An applicant who is required to meet the SNAP employment and training requirements in OAR 461-130-0305 and 461-130-0315, who voluntarily and without good cause (see OAR 461-130-0327) quits a job or reduces the weekly number of hours of work to below 30, is ineligible for SNAP benefits.

(2) For purposes of this rule, an individual quits a job upon quitting a job of at least 30 hours a week or the equivalent of 30 hours a week multiplied by the federal minimum wage.

(3) The period of ineligibility is determined as follows. If the filing date falls within the 30-day period following a job quit or work reduction described in sections (1) and (2) of this rule, the person who quit the job or reduced work hours will be ineligible during the month in which the filing date falls and for the appropriate disqualification of one, three or six calendar months (see OAR 461-130-0330).

Stat. Auth: ORS 411.816
Stats. Implemented: ORS 411.816
Hist.: AFS 10-2001(Temp), f. 6-29-01, cert. ef. 7-1-01 thru 10-1-01; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 14-2016(Temp), f. 3-24-16, cert. ef. 4-1-16 thru 9-27-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-145-0360
Motor Vehicle

(1) The value of disability-related apparatus, optional equipment, or low mileage is not considered in determining the fair market value (see OAR 461-001-0000) of an automobile, truck, or van. The fair market value of an automobile, truck, or van is presumed to be the "average trade-in value" established in the National Automobile Dealers Association's (NADA) Used Car Guide, Kelley Blue Book, or similar publication. A client may rebut the presumption with a statement from a car dealer, mechanic, or other reliable source. If the vehicle is not listed in the NADA Used Car Guide, Kelley Blue Book, or a similar publication, the estimate of the value by the client may be accepted unless it appears questionable, in which case additional evidence of the value is required.

(2) Some programs permit an exclusion for a portion of the equity value (see OAR 461-001-0000) for any licensed and unlicensed motor vehicles owned by the financial group (see OAR 461-110-0530):

(a) In the REF, REFM, SNAP, and TANF programs, this exclusion is up to $10,000.

(b) In the GA and GAM programs, this exclusion is up to $4,500.

(c) Any remaining equity in that vehicle and the total equity value of all other vehicles is counted as a resource.

(3) In the EA and ERDC programs, all motor vehicles are excluded.

(4) In the OSIP, OSIPM, and QMB-DW programs:

(a) The total value of a vehicle selected by the financial group is excluded if it is used for transportation of the client or a member of the client's household.

(b) The total equity value of any vehicle not excluded under subsection (a) of this section and all other vehicles is counted as a resource.

(5) In the OSIP-EPD and OSIPM-EPD programs, if a vehicle was purchased as an employment and independence expense (see OAR 461-001-0035) or with moneys from an approved account (see OAR 461-001-0035), the total value of the vehicle is excluded.

Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.117, 411.404, 411.704, 411.706, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.117, 411.404, 411.704, 411.706, 411.816, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 27-1996, 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 19-1997, f. & cert. ef. 10-1-97; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; 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 9-1999, f. & cert. ef. 7-1-99; 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 17-2004, f. & cert. ef. 7-1-04; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

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 2 years.

(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 2 years 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 Office of Child Care.

(d) The Certified Family Rate applies to child care provided in a residential dwelling that is certified by the Office of Child Care 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 Office of Child Care 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 subsection (b) of this section.

(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 (b) or (f) of this section.

(h) The Certified Center Rate applies to child care provided in a center that is certified by the Office of Child Care.

(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.

(h) Child care providers are eligible to receive an incentive payment upon achieving and maintaining a three star or higher rating with the Quality Rating Improvement System (QRIS) subject to all of the following provisions.

(A) The incentive payment is in addition to the Department maximum rate.

(B) A provider may receive an incentive payment for any ERDC child that the Department paid the provider for full-time care (136 hours or more).

(C) Providers who are contracted for child care services through the ERDC program are not eligible to receive incentive payments.

(D) Eligibility for the incentive payment is effective the month after the QRIS rating has been achieved.

(E) The incentive payment amount is based on the provider's star QRIS rating as follows: [Table not included. See ED. NOTE.]

(4) The following are the child care rates 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) or (13) of this rule or for children in contracted child care (see OAR 461-135-0405 and 461-135-0407), this section establishes the ERDC eligibility standard and the client's copayment (copay).

(a) At initial certification, the ERDC eligibility standard is met for a need group (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. The eligibility standard for a need group of eight applies to any need group larger than eight.

(b) During the certification period (see OAR 461-001-0000) and at recertification the ERDC eligibility standard is met for a need group of eight or less if monthly countable income for the need group during the 12 month period is less than 250 percent FPL or 85 percent state median income (SMI), whichever is higher, as described in OAR 461-155-0180. The eligibility standard for a need group of eight applies to any need group larger than eight.

(c) The minimum monthly ERDC copay is $25.

(d) The filing group may not exceed the resource limit in OAR 461-160-0015.

(e) For a filing group (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.

(f) For a filing group whose countable income is over 50 percent of the 2007 FPL, the copay amount is determined with the following percentage of monthly income:

(A) Divide the filing group's countable income by the 2007 FPL, drop all digits beyond two decimal points, subtract 0.5, and multiply this difference by 0.12.

(B) Add .015 to the amount in paragraph (A) of this subsection. This sum is the percentage of monthly income used to determine the copay amount. Multiply this sum by the filing group's countable income and round to the nearest whole dollar.

(g) The 2007 federal poverty level used to determine copay amounts under subsections (d) and (e) 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 the amounts in paragraphs (A) or (B) of this subsection:

(A) 125 percent of the number of child care hours authorized:

(i) Under OAR 461-160-0040(2) and (5); or

(ii) 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.

(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).

(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.

(d) In the ERDC program, employed caretakers eligible under OAR 461-135-0400 may have education hours added to the authorized work hours. Education hours may not exceed authorized work hours and combined hours may not exceed 215 hours per month. Education hours are hours required to participate in coursework that leads to a certificate, degree, or job-related knowledge or skills attainment at an institution of higher education approved to receive federal financial aid.

(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 required to keep current employment, not including self-employment. 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.

(11) The payment available for care of a child who meets the special needs criteria described in subsection (e) of section (1) 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.

(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) Effective 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 copay amount set under section (5) of this rule by multiplying the copay amount by 1.1 and rounding down to the nearest whole dollar.

(13) Effective April 1, 2016, the ERDC copay is $27 for no more than three months after closure of Pre-TANF, SFPSS, or TANF benefits when:

(a) The closure is because an individual in the need group had earned income that led to the TANF closure;

(b) An ERDC date of request (see OAR 461-115-0030) is established within 90 days of closure; and

(c) The individual is eligible for ERDC.

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

Stat. Auth.: ORS 329A.500, 409.050, 411.060, 411.070, 412.006, 412.049

Stats. Implemented: ORS 329A.500, 409.010, 409.050, 409.610, 411.060, 411.070, 411.122, 411.141, 412.006, 412.049, 412.124, 418.485

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; SSP 31-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 35-2013, f. & cert. ef. 11-1-13 thru 3-30-14; SSP 8-2014, f. & cert. ef. 3-31-14; SSP 14-2015(Temp), f. & cert. ef. 3-23-15 thru 9-18-15; SSP 17-2015, f. & cert. ef. 6-30-15; SSP 23-2015, f. 9-28-15, cert. ef. 10-1-15; SSP 33-2015(Temp), f. 12-18-15, cert. ef. 1-1-16 thru 6-28-16; SSP 7-2016(Temp), f. 2-17-16, cert. ef. 3-1-16 thru 6-28-16; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-160-0010

Use of Resources in Determining Financial Eligibility

Countable (see OAR 461-001-0000) resources are used to determine eligibility (see OAR 461-001-0000) as follows:

(1) In the EA program, the countable resources of a financial group (see OAR 461-110-0530) are used to reduce benefits.

(2) In the ERDC, GA, GAM, QMB-DW, REF, SNAP, and TANF programs, a need group (see OAR 461-110-0630) is not eligible for benefits if the financial group has countable resources above the resource limit (see OAR 461-160-0015).

(3) In the OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) programs, a need group (see OAR 461-110-0630) is not eligible for benefits if the financial group has countable resources above the resource limit (see OAR 461-160-0015).

(a) When a child (see OAR 461-001-0000) is applying, the parental resources (see subsection (b) of this section) are deemed available to the child. The amount deemed available to the child is the amount the parental resources exceed the resource limit (see OAR 461-160-0015) of:

(A) A one person need group, if one parent (see OAR 461-001-0000) lives in the child's household; or

(B) A two person need group, if two parents (or one parent and the spouse (see OAR 461-001-0000) of that parent) live in the child's household.

(b) As used in this section, "parental resources" means the countable resources of:

(A) Each parent in the child's financial group, and

(B) Each spouse of a parent in the child's financial group.

(c) If more than one child is applying, the value of the deemed resources is divided evenly between the applying children.

(d) The parental resources are not deemed available to an ineligible child.

(e) The value of the parental resources is subject to deeming whether or not those resources are available to the child.

(4) In the OSIP-EPD and OSIPM-EPD programs:

(a) A need group is not eligible for benefits if the financial group has countable resources above the resource limit (see OAR 461-160-0015).

(b) Any money in an approved account (see OAR 461-001-0035) is excluded during the determination of eligibility.

(c) Assets purchased from moneys in an approved account are excluded, provided they meet the requirements of OAR 461-145-0025.

(d) Assets purchased as employment and independence expenses (see OAR 461-001-0035) are excluded, provided they meet the requirements of OAR 461-145-0025.

(5) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, all resources are excluded and have no effect on eligibility (see OAR 461-160-0015).

Stat. Auth.: ORS 411.060, 411.070, 411.400, 411.404, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 411.060, 411.070, 411.117, 411.400, 411.404, 411.816, 412.049, 413.085, 414.685, 414.839

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 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 17-1998, f. & cert. ef. 10-1-98; 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 9-1999, f. & cert. ef. 7-1-99; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 9-2013(Temp), f. & cert. ef. 4-10-13 thru 10-7-13; SSP 24-2013, f. & cert. ef. 10-1-13; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-160-0015

Resource Limits

(1) In the EA program, all countable (see OAR 461-001-0000) resources must be used to meet the emergent need.

(2) In the ERDC program, the limit is $1,000,000.

(3) In the REFM program, there is no resource limit.

(4) In the GA, GAM, OSIP, and OSIPM programs, the resource limit is as follows:

(a) $2,000 for a one-person need group (see OAR 461-110-0630) and $3,000 for a two-person need group.

(b) $1,000 for an OSIP need group eligible under OAR 461 135 0771. The total cash resources may not exceed $500 for a one-person need group or $1,000 for a two-person need group.

(c) $5,000 for the OSIP-EPD and OSIPM-EPD programs (see OAR 461-001-0035 and 461-145-0025 for funds that may be excluded as approved accounts).

(5) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, all resources are excluded.

(6) In the QMB-DW program, the resource limit is amended in January of each year based on the low income subsidy for Medicare Part D as published by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Effective January 1, 2015 the resource limit is $7,280 for a one-person need group and $10,930 for a need group containing two or more individuals.

(7) In the REF program, the resource limit is:

(a) $2,500 for any of the following:

(A) A new REF applicant for benefits.

(B) REF need group that has at least one mandatory (see OAR 461-130-0305) participant in an employment program who is:

(i) Receiving REF and not progressing in a required activity of an open case plan; or

(ii) Serving a current employment program disqualification (see OAR 461-130-0330).

(b) $10,000 for a need group not covered under subsection (a) of this section.

(8) In the SNAP program, the resource limit is:

(a) $3,250 for a financial group (see OAR 461-110-0530) with at least one member who is elderly (see OAR 461-001-0015) or an individual with a disability (see OAR 461-001-0015).

(b) $2,250 for all other financial groups.

(9) In the TANF program, the resource limit is:

(a) $2,500 for any of the following:

(A) A new TANF applicant for benefits.

(B) TANF need group that does not have at least one caretaker relative (see OAR 461-001-0000) or parent (see OAR 461-001-0000) who is receiving TANF.

(C) TANF need group that has at least one JOBS participant who is:

(i) Receiving TANF and not progressing in an activity (see OAR 461-001-0025) of an open JOBS case plan (see OAR 461-001-0025); or

(ii) Serving a current JOBS disqualification (see OAR 461-130-0330).

(b) $10,000 for a need group not covered under subsection (a) of this section.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.083, 411.404, 411.706, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.083, 411.404, 411.704, 411.706, 411.816, 411.837, 412.049, 413.085, 414.685, 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 13-1991, f. & cert. ef. 7-1-91; AFS 20-1991, f. & cert. ef. 10-1-91; 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 23-1994, f. 9-29-94, cert. ef. 10-1-94; 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 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 27-1996, 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 10-1998, f. 6-29-98, cert. ef. 7-1-98; 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 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 17-2003, f. & cert. ef. 7-1-03; 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 17-2004, f. & cert. ef. 7-1-04; SSP 22-2004, f. & cert. ef. 10-1-04; 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 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-1; 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 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 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; 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 27-2013, f. & cert. ef. 10-1-13; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 26-2014(Temp), f. & cert. ef. 10-1-14 thru 3-30-15; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-160-0410
Use of Income and Income Deductions When There Are Ineligible or Disqualified Group Members; SNAP

When a member of the filing group (see OAR 461-110-0310 and 461-110-0370) is not in the need group (see OAR 461-110-0630), benefits in the SNAP program are calculated as follows:

(1) If the member is a qualified non-citizen (see OAR 461-120-0125(1)(a)–(g)) who does not meet the alien status requirements, the following procedure is used:

(a) Benefits are calculated as if the qualified non-citizen is eligible. Benefits are then calculated as if the qualified non-citizen is not a member of the filing group. Any income received by another member of the filing group from the qualified non-citizen is counted as income of the filing group. No expenses paid by the qualified non-citizen are deducted from gross income.

(b) The household's benefits are the lesser of the amounts calculated in subsection (a) of this section.

(2) The process described in sections (3) and (4) of this rule is used if the member is:

(a) A non-citizen but not a qualified non-citizen;

(b) Disqualified for failing to obtain or provide a Social Security Number;

(c) Unwilling to disclose alien status; or

(d) An ABAWD (see OAR 461-135-0520) who is ineligible because of the time limit in OAR 461-135-0520.

(3) If the member is in a group described in section (2) of this rule:

(a) The member's countable (see OAR 461-001-0000) income is prorated among the members in the filing group.

(b) The pro rata share of each individual not in the benefit group (see OAR 461-110-0750) is excluded.

(c) The rest of the prorated income is countable income for the filing group.

(4) An ineligible or disqualified member covered by section (2) of this rule is entitled to all income deductions for which the member qualifies. When paid by the member, or billed to the member and unpaid, deductions for shelter, child support, medical costs, and dependent care are calculated as follows:

(a) The deductions, except deductions for the utility standard, are prorated among the members of the filing group.

(b) The prorated share of the members of the benefit group is deducted.

(c) The deduction for the utility standard is made in accordance with OAR 461-160-0420.

(5) The countable income of the following financial group (see OAR 461-110-0530) members, subject to allowable deductions, is used to determine benefits:

(a) A client disqualified for failure to comply with the requirements of the OFSET program or because of an intentional program violation.

(b) A client:

(A) Fleeing to avoid prosecution, or custody or confinement after conviction, under the law of the place from which the client is fleeing, for a crime, or attempt to commit a crime, that is a felony under the law of the place from which the client is fleeing or that, in the case of New Jersey, is a high misdemeanor under the law of New Jersey; or

(B) Violating a condition of probation or parole imposed under a federal or state law.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.816
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.816, 411.837
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 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 20-1991, f. & cert. ef. 10-1-91; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 27-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-979; 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 10-2001(Temp), f. 6-29-01, cert. ef. 7-1-01 thru 10-1-01; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 6-2002(Temp), f. & cert. ef. 4-1-02 thru 6-30-02; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 23-2003, f. & cert. ef. 10-1-03; 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 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 20-2015(Temp), f. & cert. ef. 7-1-15 thru 12-27-15; SSP 28-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 14-2016(Temp), f. 3-24-16, cert. ef. 4-1-16 thru 9-27-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-165-0010
Legal Status of Benefit Payments

(1) Under Oregon law, cash benefits are not subject to assignment, transfer, garnishment, levy, or execution, as long as they can be identified as program payments and are separate from other money in the client's possession.

(2) A cash payment, once issued to or on behalf of the client, becomes vested in the client.

(3) Except for electronic benefit transfer (EBT), the Department considers a benefit issued if the check has been handed to the client in the branch office, or mailed to the client. The Department considers a benefit issued, and received by the client, when a direct check deposit is made to the client's bank account.

(4) For EBT, the Department considers benefits issued and received when an EBT card and personal identification number (PIN) have been issued in person to the client, or the EBT card and PIN have been received by the client in the mail during conversion, and the benefits have been deposited to the client's EBT account.

(5) SNAP program benefits issued by EBT remain available for client access for 12 calendar months from the date of issuance. The EBT system expunges unused benefits after 12 calendar months.

(6) Benefits, once issued, are unrestricted and do not require accountability for individual expenditures or amounts, unless limited elsewhere in rule.

(7) In the TA-DVS program, a payment issued on behalf of a client as a vendor or dual payee payment or directly to the client becomes vested in the client when issued. The Department considers the benefit to be issued if the Department has mailed the payment to the vendor or has hand delivered or mailed a dual payee check to the client. Benefits in the TA-DVS program are restricted to uses outlined in OAR 461-135-1230.

(8) In the REF program:

(a) Cash benefits are provided to help meet the basic needs of low-income refugees and may not be used in any electronic benefit transfer transaction (see section (10) of this rule) in:

(A) Any liquor store (see section (10) of this rule);

(B) Any casino, gambling casino, or gaming establishment;

(C) Any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment; or

(D) Any marijuana dispensary.

(b) The Department will take steps to ensure clients have adequate access to their cash benefits.

(9) In the SFPSS and TANF programs:

(a) Cash benefits are provided to help meet the basic needs of low-income families with dependent children (see OAR 461-001-0000) and may not be used in any electronic benefit transfer transaction in:

(A) Any liquor store;

(B) Any casino, gambling casino, or gaming establishment;

(C) Any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment; or

(D) Any marijuana dispensary.

(b) The Department will take steps to ensure clients have adequate access to their cash benefits.

(10) For purposes of sections (8) and (9) of this rule:

(a) The term "liquor store" means any retail establishment which sells exclusively or primarily intoxicating liquor. Such term does not include a grocery store which sells both intoxicating liquor and groceries including staple foods (as defined in the Food and Nutrition Act of 2008 (7 U.S.C. 2012)).

(b) The terms "casino", "gambling casino", and "gaming establishment" do not include:

(A) A grocery store which sells groceries including such staple foods and which also offers, or is located within the same building or complex as, casino, gambling, or gaming activities; or

(B) Any other establishment that offers casino, gambling, or gaming activities incidental to the principal purpose of the business.

(c) The term "electronic benefit transfer transaction" means the use of a credit or debit card service, automated teller machine, point-of-sale ter-

minal, or access to an online system for the withdrawal of funds or the processing of a payment for merchandise or a service.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.816, 412.006, 412.014, 412.049
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.117, 411.816, 411.837, 412.006, 412.014, 412.049, 412.151
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 11-1991, f. 4-30-91, cert. ef. 5-1-91; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 5-2013, f. & cert. ef. 2-6-13; SSP 19-2015, f. & cert. ef. 7-1-15; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-165-0180
Eligibility of Child Care Providers

(1) The Department must approve a child care provider to receive payment for child care if information available to the Department provides no basis for denying eligibility unless the Department determines, following a preliminary or final fitness determination (see OAR 407-007-0320) or Child Protective Service (CPS) records checks, that the provider or other subject individual (see OAR 407-007-0210(30)(a)(A), (B), (F), (I), and (P)) is not eligible for payment.

(2) Ineligibility for payment may result from any of the following:

(a) A finding of "denied".

(A) A provider may be denied under OAR 461-165-0410 and 461-165-0420. If, after conducting a weighing test as described in OAR 407-007-0210, the Department finds substantial risk to the health or safety of a child (see OAR 461-001-0000) in the care of the provider, the provider must be denied and is ineligible for payment.

(B) A provider who has been denied has the right to a hearing under OAR 407-007-0330.

(b) A finding of "failed".

(A) A provider may be failed if the Department determines, based on a specific eligibility requirement and evidence, that a provider does not meet an eligibility requirement of this rule not covered in paragraph (c)(A) of this section.

(B) While the provider is in failed status:

(i) The Department does not pay any other child care provider for child care at the failed provider's site.

(ii) The Department does not pay a child care provider at another site if the failed provider is involved in the child care operation unless the Department determines that the reasons the provider is in failed status are not relevant to the new site.

(C) A provider with a status of "failed" may reapply at any time by providing the required documents and information to the Department for review.

(c) A finding of "suspended".

(A) A provider may be suspended if the Department determines and provides notice that the provider does not meet an eligibility requirement in the following subsections and paragraphs of section (7) of this rule: (d), (e), (h), (i), (j), (k), (L), (o)(H), (o)(I), (o)(L), or (t) or in section (10) of this rule. A provider who has been suspended may challenge this status by requesting a contested case hearing subject to the requirements and limitations of OAR 461-025.

(B) While the provider is in suspended status:

(i) The provider is ineligible for payment for at least six months.

(ii) The Department does not pay any other child care provider for child care at the suspended provider's site.

(iii) The Department does not pay a child care provider at another site if the suspended provider is involved in the child care operation unless the Department determines that the reasons the provider is in suspended status are not relevant to the new site.

(C) A provider with a status of "suspended" may be eligible for payments after the six month ineligibility period ends when the provider has been approved following reapplication, including providing the required documents and information to the Department for review.

(d) The Department has referred an overpayment against the provider for collection and the claim is unsatisfied.

(3) The provider must submit a completed Child Care Provider Listing Form (DHS 7494) to the Department within 30 calendar days from the date the Department issues the listing form to the client. The provider and each individual identified under section (4) of this rule must complete and sign the authorization for a records check through the Criminal History (CH) record system maintained by the Oregon State Police (OSP), Federal Bureau of Investigation (FBI), and the Child Protective Service (CPS) record system maintained by the Department and, if necessary, an authorization to release information and fingerprint cards. The provider, each individual described in section (4) of this rule, and each subject individual described in OAR 407-007-0210(30)(a)(A), (B), (F), (I) or (P) must fully disclose all requested information as part of the records check.

(4) This rule also establishes additional requirements for the following individuals:

(a) The site director of an exempt child care facility and each employee of the facility who may have unsupervised access to a child in care.

(b) The child care provider and each individual the provider uses to supervise a child in his or her absence.

(c) In the case of a provider who provides care for a child in the provider's home:

(A) Each individual 16 years of age or older who lives in the provider's home; and

(B) Each individual who visits the home of the provider during the hours care is provided and may have unsupervised access to a child in care.

(5) To receive payment or authorization for payment, the provider must meet the requirements of either subsection (a) or (b) of this section:

(a) Currently be certified or registered with the Office of Child Care (OCC) of the Oregon Department of Education (ODE) under OAR 414-205-0000 to 414-205-0170, 414-300-0000 to 414-300-0440, or 414-350-0000 to 414-350-0250 unless legally exempt, and be in compliance with the applicable rules. The provider must also complete the Department's listing process and be approved by the Department.

(b) If legally exempt from being certified or registered with the OCC, complete the Department's background check process and be approved by the Department.

(6) Each individual described in section (4) of this rule must:

(a) Allow the Department to conduct a national criminal history records check through the Oregon State Police and the Federal Bureau of Investigation as specified in OAR 407-007-0250.

(b) Provide, in a manner specified by the Department, information required to conduct CH, FBI, OSP, and CPS records checks and determine whether the provider meets health and safety requirements.

(c) Have a history of behavior that indicates no substantial risk to the health or safety of a child in the care of the provider.

(7) Each provider must:

(a) Obtain written approval from their certifier or certifier's supervisor if the provider is also certified as a foster parent.

(b) Be 18 years of age or older and in such physical and mental health as will not affect adversely the ability to meet the needs of safety, health, and well-being of a child in care.

(c) Not be in the same filing group (see OAR 461-110-0350) as the child cared for and cannot be the parent (see OAR 461-001-0000) of a child in the filing group.

(d) Allow the Department to inspect the site of care while child care is provided.

(e) Keep daily attendance records showing the arrival and departure times for each child in care and billing records for each child receiving child care benefits from the Department. These written records must be retained for a minimum of 12 months and provided to the Department upon request.

(f) Be the individual or facility listed as providing the child care. The provider may only use someone else to supervise a child on a temporary basis if the person was included on the most current listing form and the provider notifies the Department's Direct Pay Unit.

(g) Not bill a Department client for an amount collected by the Department to recover an overpayment or an amount paid by the Department to a creditor of the provider because of a lien, garnishment, or other legal process.

(h) Report to the Department's Direct Pay Unit within five days of occurrence:

(A) Any arrest or conviction of any subject individual or individual described in section (4) of this rule.

(B) Any involvement of any subject individual or individual described in section (4) of this rule with CPS or any other agencies providing child or adult protective services.

(C) Any change to the provider's name or address including any location where care is provided.

(D) The addition of any subject individual or individual described in section (4) of this rule.

(E) Any reason the provider no longer meets the requirements under this rule.

(i) Report suspected child abuse of any child in his or her care to CPS or a law enforcement agency.

(j) Supervise each child in care at all times.

(k) Prevent any individual who behaves in a manner that may harm children from having access to a child in the care of the provider. This includes anyone under the influence (see section (11) of this rule).

(L) Allow the custodial parent of a child in his or her care to have immediate access to the child at all times.

(m) Inform a parent of the need to obtain immunizations for a child and have a completed, up-to-date Oregon shot record called the "Certification of Immunization Status" (CIS) form on file for each child in care.

(n) Take reasonable steps to protect a child in his or her care from the spread of infectious diseases.

(o) Ensure that the home or facility where care is provided meets all of the following standards:

(A) Each floor level used by a child has two usable exits to the outdoors (a sliding door or window that can be used to evacuate a child is considered a usable exit). If a second floor is used for child care, the provider must have a written plan for evacuating occupants in the event of an emergency.

(B) The home or facility has safe drinking water.

(C) The home or facility has a working smoke detector on each floor level and in any area where a child naps.

(D) Each fireplace, space heater, electrical outlet, wood stove, stairway, pool, pond, and any other hazard has a barrier to protect a child. Gates and enclosures have the Juvenile Products Manufacturers Association (JPMA) certification seal to ensure safety.

(E) Any firearm, ammunition, and other items that may be dangerous to children, including but not limited to alcohol, inhalants, tobacco and e-cigarette products, matches and lighters, any legally prescribed or over-the-counter medicine, cleaning supplies, paint, plastic bags, and poisonous and toxic materials are kept in a secure place out of a child's reach.

(F) The building, grounds, any toy, equipment, and furniture are maintained in a clean, sanitary, and hazard free condition.

(G) The home or facility has a telephone in operating condition.

(H) No one may smoke or carry any lighted smoking instrument, including e-cigarettes or vaporizers, in the home or facility or within ten feet of any entrance, exit, window that opens, or any ventilation intake that serves an enclosed area, during child care operational hours or anytime child care children are present. No one may use smokeless tobacco in the home or facility during child care operational hours or anytime child care children are present. No one may smoke or carry any lighted smoking instrument, including e-cigarettes and vaporizers, or use smokeless tobacco in motor vehicles while child care children are passengers.

(I) No one may consume alcohol or use controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) on the premises (see section (11) of this rule) during child care operational hours or anytime child care children are present. No one under the influence of alcohol, controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) may be on the premises during child care operational hours or anytime child care children are present. No one may consume alcohol or use controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) in motor vehicles while child care children are passengers.

(J) Is not a half-way house, hotel, motel, shelter, or other temporary housing such as a tent, trailer, or motor home. The restriction in this paragraph does not apply to licensed (registered or certified) care approved in a hotel, motel, or shelter.

(K) Is not a structure:

(i) Designed to be transportable; and

(ii) Not attached to the ground, another structure, or to any utilities system on the same premises.

(L) Controlled substances (except lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana, marijuana edibles, and other products containing marijuana), marijuana plants, derivatives, and associated paraphernalia may not be on the premises during child care operational hours or anytime child care children are present.

(p) Complete and submit a new listing form every two years, or sooner at the request of the Department, so that the Department may review the provider's eligibility.

(q) Provide evidence of compliance with the Department's administrative rules, upon request of Department staff.

(r) Comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety, and crib standards under 16 CFR 1219 and 1220.

(s) Place infants to sleep on their backs.

(t) Not hold a medical marijuana card; or distribute, grow, or use marijuana (including medical marijuana) or any controlled substance (except lawfully prescribed and over-the-counter medications).

(8) Child Care providers who are License Exempt or Registered Family Child Care Providers with the Office of Child Care (OCC) of the Oregon Department of Education (ODE) under OAR 414-205-0000 to 414-205-0170 must complete the "Basic Child Care Health and Safety" two-hour, web-based training or the three-hour Oregon Kids Healthy and Safe (OKHS) classroom training prior to being approved by the Department.

(a) Prior to June 16, 2014, a provider who sends the Department a Child Care Provider Listing and Provider Information Sheet (DHS 7494) with a revision date of March 2013, or those who attempt to take the web-based training but are unable due to technical difficulties at the training site, will not be failed for not meeting this training requirement.

(b) License Exempt or Registered Family Child Care Providers who are exempt from this training are those who state at least one of the following:

(A) English is a second language.

(B) No internet access is available.

(9) A child care provider not subject to certification or registration with the Office of Child Care (OCC) of the Oregon Department of Education (ODE) under OAR 414-205-0000 to 414-205-0170, 414-300-0000 to 414-300-0440, or 414-350-0000 to 414-350-0250, must complete an orientation provided by the Department or a Child Care Resource and Referral agency within 90 days of being approved by the Department if he or she:

(a) Receives funds from the Department; and

(b) Begins providing child care services after June 30, 2010, or resumes providing child care services, after a break of more than one year that began after June 30, 2010.

(10) Child care providers and any individual supervising, transporting, preparing meals, or otherwise working in the proximity of child care children and those completing daily attendance and billing records shall not be under the influence.

(11) For purposes of these rules:

(a) "Premises" means the home or facility structure and grounds, including indoors and outdoors and space not directly used for child care.

(b) "Under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the individual has used alcohol, any controlled substances (including lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana), or inhalants that impairs their performance of essential job function or creates a direct threat to child care children or others. Examples of abnormal behaviors include, but are not limited to hallucinations, paranoia, or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech as well as difficulty walking or performing job activities.

Stat. Auth.: ORS 181.537, 329A.500, 409.050, 411.060, 411.070

Stats. Implemented: ORS 181.537, 329A.340, 329A.500, 409.010, 409.050, 409.610, 411.060, 411.070, 411.122

Hist.: 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 17-1994(Temp), f. & cert. ef. 8-15-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 2-1997, f. 2-27-97, cert. ef. 3-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 12-1997, f. & cert. ef. 8-25-97; AFS 14-1999, f. & cert. ef. 11-1-99; 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 12-2001, f. 6-29-01, cert. ef. 7-1-01; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 13-2004, f. 4-29-04, cert. ef. 5-1-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 6-2005(Temp), f. & cert. ef. 4-25-05 thru 9-30-05; 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 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 5-2014(Temp), f. 2-4-14, cert. ef. 3-1-14 thru 8-28-14; SSP 10-2014(Temp), f. & cert. ef. 4-1-14 thru 8-28-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 21-2014(Temp), f. & cert. ef. 8-13-14 thru 2-9-15; SSP 6-2015, f. 1-30-15, cert. ef. 2-1-15; SSP 17-2015, f. & cert. ef. 6-30-15; SSP 3-2016(Temp), f. & cert. ef. 1-20-16 thru 7-17-16; SSP 12-2016(Temp), f. & cert. ef. 3-14-16 thru 7-17-16; SSP 22-2016(Temp), f. & cert. ef. 5-23-16 thru 11-18-16; SSP 27-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 11-18-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-175-0200

Notice Situations; General Information

(1) In the EA program, a basic decision notice (see OAR 461-001-0000) is sent for all situations.

(2) In the SNAP program, a basic decision notice is sent for all actions on applications for assistance.

(3) In the JOBS program:

(a) A basic decision notice is sent whenever a request for a support service payment is denied.

(b) No decision notice is required if request for a support service is approved.

(4) A basic decision notice is sent to close JPI benefits when the filing group (see OAR 461-110-0310) reports a change during the reporting period in which SNAP benefits do not decrease.

(5) In the TANF program, a notice approving benefits informs the client, within one month following eligibility determination, of the opportunity to volunteer for JOBS participation and of the procedure for JOBS program entry.

(6) In the Pre-TANF program, a basic decision notice is sent when payment for basic living expenses is denied or when payment for other support services in the JOBS program is denied. No other notices are required for this program.

(7) In the TA-DVS program, a basic decision notice (see OAR 461-001-0000) is sent to a safe mailing address or hand delivered for all situations. This includes when the program is approved, denied, or closed (prior to the end of the 90 day eligibility period) and when a payment under the program is denied.

(8) In all programs except the Pre-TANF program, unless stated differently in this rule or another rule, the Department mails or otherwise provides the client with (sends) a decision notice (see OAR 461-001-0000) as follows:

(a) A basic decision notice is sent whenever an application for assistance, including retroactive medical assistance, is approved or denied or a request for a support service payment in the JOBS program is denied.

(b) A timely continuing benefit decision notice (see OAR 461-001-0000) is sent whenever benefits or support service payments authorized by OAR 461-190-0211 are reduced or closed, or the method of payment changes to protective, vendor, or two-party.

(c) A decision notice is sent whenever the Department adjusts previously underissued cash assistance or SNAP benefits.

(9) In all programs:

(a) Notwithstanding any rule in Chapter 461, to the extent permitted by OAR 137-003-0530, the Department may take any of the following actions:

(A) Amend a decision notice with another decision notice or a contested case notice.

(B) Amend a contested case notice.

(C) Delay a reduction or closure of benefits as a result of a client's request for hearing.

(D) Extend the effective date on a decision notice or contested case notice.

(b) Except as provided in subsection (a) of this section or when a delay results from the client's request for a hearing, a notice to reduce or close benefits becomes void if the reduction or closure is not initiated on the date stated on the notice. If the notice is void, a new notice is sent to inform the financial group (see OAR 461-110-0530) of a new date on which their benefits will be reduced or closed.

(c) No decision notice is required in each of the following situations:

(A) Benefits are ended because there is no living person in the benefit group (see OAR 461-110-0750).

(B) A notice was sent, the client requested a hearing, and either the hearing request is dismissed or a final order is issued.

(C) The client has signed a voluntary agreement that qualifies as a final order under ORS 183.417(3)(b) (see OAR 461-175-0340(2)) except as provided otherwise in OAR 461-175-0220.

(D) To end Employment Payments (see OAR 461-001-0025 and 461-135-1270) or JPI benefit (see OAR 461-135-1260) when the individual has applied for and been found eligible for Pre-TANF, SFPSS, or TANF.

(E) No decision notice is required in OAR 461-175-0300 based on prior notice.

(d) When the Department amends a decision notice with another decision notice under subsection (a) of this section, the date of the amended notice restarts the client's deadlines to request a hearing or continuing benefits, or both.

(e) When a contested case notice extends an effective date or delays a reduction or closure, the date of the amended notice restarts a client's timeline to request continuing benefits.

(f) When a client has a pending hearing request or is receiving continuing benefits, and the Department amends a notice under this section, the client need not re-file the hearing request or renew the request for continuing benefits.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049

Stats. Implemented: ORS 183.415, 183.417, 411.060, 411.070, 411.117, 411.404, 411.706, 411.816, 412.014, 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 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 9-1999, f. & cert. ef. 7-1-99; 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 27-2001, f. 12-21-01, cert. ef. 1-1-02; 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 21-2004, f. & cert. ef. 10-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 16-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-27-08; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 11-2008(Temp), f. & cert. ef. 4-7-08 thru 9-30-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 28-2009, f. & cert. ef. 10-1-09; SSP 3-2010(Temp), f. & cert. ef. 2-23-10 thru 8-22-10; SSP 18-2010, f. & cert. ef. 7-1-10; 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 17-2011, f. & cert. ef. 7-1-11; SSP 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 27-2015(Temp). f. 9-29-15, cert. ef. 10-1-15 thru 3-28-16; SSP 2-2016, f. & cert. ef. 1-1-16; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-175-0220
Notice Situation; Disqualification

(1) If a benefit group (see OAR 461-110-0750) or individual is disqualified for a SNAP voluntary job quit or for failure to apply for or provide an SSN, pursue assets, cooperate in the JOBS, JOBS Plus, or OFSET program, or assist the state's efforts to collect support, the Department sends the following type of notice:

(a) If benefits are reduced or closed because of the disqualification:

(A) A continuing benefit decision notice (see OAR 461-001-0000) is used when changes are reported on the Interim Change Report form.

(B) A timely continuing benefit decision notice (see OAR 461-001-0000) is used when changes are not reported on the Interim Change Report form.

(b) If benefits are opened without the disqualified individual in the benefit group or if the entire benefit group is denied assistance, a basic decision notice (see OAR 461-001-0000) is used.

(2) For a JOBS, JOBS Plus, or OFSET disqualification, and for a SNAP voluntary job quit by an individual receiving SNAP benefits, the notice includes the following information:

(a) The client action that resulted in disqualification.

(b) The length of the minimum disqualification period.

(c) The reduced benefit amount.

(d) How the client may end the disqualification after the minimum period.

(3) For a voluntary job quit by an individual applying for SNAP benefits, the notice includes the following information:

(a) The action that resulted in the disqualification; and

(b) The length of the disqualification period.

(4) For an IPV disqualification:

(a) In all programs except the SNAP program, the Department does not send a notice of termination to an individual disqualified for an IPV after a court order, a final order from an administrative hearing, or a signed waiver (see OAR 461-175-0200(9)(c)(C) and 461-195-0621(2)) that imposes the disqualification.

(b) In the SNAP program:

(A) After an individual signs an IPV waiver, the Department sends a basic decision notice to terminate benefits. If the Department receives a timely request for a hearing, the contested case hearing addresses the issues set out in OAR 461-195-0611(3).

(B) The Department does not send a notice of termination to an individual disqualified for an IPV after a court order or a final order from an administrative hearing.

(c) In all programs, the Department sends a continuing benefit decision notice when benefits for other individuals in the benefit group are closed or reduced because an individual in the benefit group is disqualified for an IPV.

(5) For a disqualification due to being a fleeing felon or in violation of parole, probation, or post-prison supervision (under OAR 461-135-0560):

(a) A basic decision notice is required if benefits are opened without the disqualified individual in the benefit group or if the entire filing group is denied benefits.

(b) A timely continuing benefit decision notice is required if an individual in the benefit group is disqualified.

(6) The notice situation for a disqualification due to a transfer of assets is covered in OAR 461-175-0310.

Stat. Auth.: 411.060, 411.070, 411.404, 411.816, 412.014, 412.049

Stats. Implemented: 411.060, 411.070, 411.404, 411.816, 412.014, 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; 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 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; SSP 20-2003, f. & cert. ef. 8-15-03; 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 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 2-2016, f. & cert. ef. 1-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-180-0135

Effective Dates; Restoring SNAP Benefits for ABAWD Following Counting Month (Not Regaining)

(1) In the SNAP program, benefits may be restored effective the first of the month when SNAP benefits for an ABAWD (see OAR 461-135-0520) end following the third countable month when all of the following requirements are met:

(a) Benefits ended as of the last calendar day of the prior month or were reduced as of the first day of the current month.

(b) The reason for the closure or reduction was the ABAWD lost eligibility (see OAR 461-001-0000) due to the time limit in OAR 461-135-0520.

(c) The client contacted the Department within the first calendar month following the closure or reduction and provided information that the client met one of the following in at least one of the first three countable months (see OAR 461-135-0520):

(A) An exemption in OAR 461-130-0310(3)(a)(A)–(J).

(B) The work requirements in OAR 461-135-0520(3)(d) or (e).

(d) There is at least one month remaining in the certification period (see OAR 461-001-0000).

(2) This policy does not include regaining eligibility (see OAR 461-135-0520(5)) or to the month following closure or reduction following receipt of six countable months or any month thereafter.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.816

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.816, 411.825, 411.837

Hist.: SSP 14-2016(Temp), f. 3-24-16, cert. ef. 4-1-16 thru 9-27-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

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 available to the following individuals:

(a) An individual who is an adult parent, needy caretaker relative (see OAR 461-001-0000), or teen parent (see OAR 461-001-0000) receiving TANF who is not otherwise exempt (see OAR 461-130-0305) and in accordance with participation requirements in OAR 461-130-0310.

(b) An individual who is an applicant or recipient in the Pre-TANF, Post-TANF, or SFPSS program.

(c) Subject to local services and budget, an individual who is exempt from JOBS requirements as a one-parent household with a dependent child (see OAR 461-001-0000) under six months of age and has approved activities as specified in the individual's case plan (see OAR 461-001-0025).

(d) 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).

(e) An individual who has become over-income for the TANF program due to earnings in an on-the-job training (see OAR 461-001-0000) activity is eligible to receive support services (see OAR 461-001-0025) for no more than three months, unless circumstances unique to the situation are identified and warrant the Department to approve a limited number of additional months. Eligibility for support services under this subsection is only permitted while the individual continues to participate in the on-the-job training activity.

(2) For eligible individuals, subject to the requirements and limitations in sections (1), (5), (6), and (7) of this rule, the following activities are 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 OAR 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) 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) activity.

(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) Rehabilitation activities (see OAR 461-001-0025).

(E) Crisis Intervention (see OAR 461-001-0025).

(F) SSI application process.

(h) Vocational training (see OAR 461-001-0025).

(i) Life skills (see OAR 461-001-0025).

(j) On-the-job training.

(k) Unsubsidized employment (work).

(L) Adult Basic Education (see OAR 461-001-0025).

(m) Job skills training (see OAR 461-001-0025).

(n) Self-initiated training (see OAR 461-001-0025).

(3) The following activities do not include support services payments:

(a) Domestic Violence Intervention.

(b) Family Support & Connections.

(c) Microenterprise (see OAR 461-001-0000).

(d) Post-TANF.

(e) Program entry (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.

(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 his or her 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 (see OAR 461-001-0000), 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.

(F) Other family stability issues that need to be addressed.

(5) In approving JOBS program support services payments, the Department must consider lower cost alternatives. This rule is not intended to supplant Department funding with other funding that is available in the community. The expectation of the Department is that case managers and clients 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, including a Not Job Ready individual approved by the district to complete a family stability activity. If authorized, payment for child care is:

(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 provided if the client or individual providing the transportation reports having 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 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 a 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 under section (1) of this rule, a Not Job Ready individual in a family stability activity, or a teen parent.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.121, 412.006, 412.009, 412.014, 412.049, 412.124

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.121, 412.001, 412.006, 412.009, 412.014, 412.049, 412.124

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; SSP 24-2013, f. & cert. ef. 10-1-13; SSP 6-2014(Temp), f.& cert. ef. 3-5-14 thru 9-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 3-2015(Temp), f. & cert. ef. 1-1-15 thru 6-29-15; SSP 17-2015, f. & cert. ef. 6-30-15; SSP 18-2015(Temp), f. 6-30-15, cert. ef. 7-1-15 thru 12-27-15; SSP 34-2015, f. 12-22-15, cert. ef. 12-28-15; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-190-0231

Re-engagement; JOBS, Pre-TANF, REF, SFPSS, TA-DVS

In the JOBS, Pre-TANF, REF, SFPSS, and TA-DVS programs:

(1) When aspects of the case plan have not been met or are in dispute, the re-engagement process provides an opportunity for the client and the Department to:

(a) Review and re-evaluate the case plan and other information gathered related to the client's strengths and barriers;

(b) Identify participation expectations, concerns related to participation, and completion of activities in the case plan;

(c) Consider whether the case plan is still appropriate;

(d) Develop options that support full participation; and

(e) Revise the case plan if appropriate.

(2) The re-engagement process is intended to assist the Department in identifying whether the client is unable to fully participate or whether the client is or has been willfully non-complaint.

(a) In the JOBS, Pre-TANF, REF, and SFPSS programs, if:

(A) A screening for physical or mental health needs, substance abuse, domestic violence (see OAR 461-001-0000), or learning needs has not been completed, the re-engagement process requires an additional opportunity to initiate those screenings for potential barriers to participation not previously identified.

(B) A screening described in paragraph (A) of this subsection indicates follow-up is needed. The re-engagement process requires an opportunity to initiate the follow-up for potential barriers to participation not previously identified.

(b) Circumstances that require a determination of whether good cause (see OAR 461-130-0327) exists include disagreements about the case plan, irregular attendance at activities, missed appointments, failure to participate in a component of the case plan, and (in the JOBS program) refusal to accept or maintain employment.

(c) In the TA-DVS program, there are no participation requirements. The re-engagement process is intended to provide an opportunity to address problems with the case plan (see OAR 461-135-1230) and an opportunity to modify the case plan.

(3) In the JOBS program, the re-engagement process must include:

(a) Assessing the risk of harm posed to the children in the filing group by the reduction in aid payments and taking steps to ameliorate the risk.

(b) An attempted home visit.

(4) The client, the Department, or the Department's contractor may initiate the re-engagement process. The re-engagement process is not a required activity. The Department may not disqualify clients based on their failure to participate in the re-engagement process.

(5) The client or Department may invite partner agencies, Department contractors, persons currently working with the client, or other individuals who have information relevant to the re-engagement process to any appointments or meetings scheduled as part of the process.

(6) The re-engagement process ends when any of the following subsections applies:

(a) The Department and the client agree to a modified case plan.

(b) Efforts to re-engage are unsuccessful.

(c) In the JOBS, Pre-TANF, and REF programs:

(A) Except in the REF program, the Department has determined the client has met federally required participation rates (see OAR 461-001-0025);

(B) The Department has determined the client is exempt from JOBS participation and disqualification under OAR 461-130-0310(2)(a).

(C) The client clearly indicates an intent not to participate in the re-engagement process;

(D) The client is willfully non-compliant and has the ability to be fully engaged;

(E) The client has no barriers or refuses to take appropriate steps to address identified barriers to participation in the program; or

(F) A decision is made by the Department that a client did not have good cause for not complying with a requirement of the JOBS program, and the client is able but unwilling to address the issue through activities that address barriers or through case plan modifications.

(d) In the SFPSS program, after a review team consisting of SFPSS program staff including the case manager, disability analyst, and appropriate medical professional determine the client does not have good cause for non-cooperation and no accommodations or modifications can be made to support the client being re-engaged.

(7) The re-engagement process must end unsuccessfully before the Department begins the process of disqualifying a client for a failure to comply with a requirement of the JOBS program.

(8) In the SFPSS program, when the re-engagement process ends unsuccessfully, a client removed from the program is returned to the TANF program.

(9) For a participant in the Parents as Scholars (PAS) component of the JOBS program, when re-engagement ends unsuccessfully, PAS is ended pursuant to OAR 461-190-0199.

Stat. Auth.: ORS 411.060, 412.009, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.117, 412.009, 412.014, 412.049
Hist.: AFS 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 9-1991, f. 3-29-91, cert. ef. 4-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 21-1995, 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 18-1998, f. & cert. ef. 10-2-98; 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 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-193-0320
Effective Dates for Cash Assistance; Refugee Case Service Project

(1) Except as provided otherwise in this rule, in the Refugee Case Service Project (RCSP), eligibility for cash assistance is effective as provided for REF and TANF clients in OAR 461-180-0070.

(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 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 461-130-0327) 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) Cash eligibility date for TANF and REF clients after a disqualification is as provided in OAR 461-130-0330.

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; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

461-195-0501
Definitions and Categories of Overpayments

This rule applies to benefits and services delivered under chapters 410, 411, and 461 of the Oregon Administrative Rules.

(1) "Overpayment" means:

(a) A benefit or service received by or on behalf of a client, or a payment made by the Department on behalf of a client, that exceeds the amount for which the client is eligible.

(b) A payment made by the Department and designated for a specific purpose which is spent by a person on an expense not approved by the Department.

(A) In the REF program, there is a rebuttable presumption that the full amount of cash benefits was improperly spent in violation of OAR 461-165-0010(8)(a) when cash benefits are used or accessed in:

(i) Any liquor store;

(ii) Any casino, gambling casino, or gaming establishment; or

(iii) Any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

(iv) Any marijuana dispensary.

(B) In the SFPSS and TANF programs, there is a rebuttable presumption that the full amount of cash benefits was improperly spent in violation of OAR 461-165-0010(9)(a) when cash benefits are used or accessed in:

(i) Any liquor store;

(ii) Any casino, gambling casino, or gaming establishment; or

(iii) Any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

(iv) Any marijuana dispensary.

(c) A payment for child care made by the Department to, or on behalf of, a client that:

(A) Is paid to an ineligible provider;

(B) Exceeds the amount for which a provider is eligible;

(C) Is paid when the client was not engaged in an activity that made the client eligible for child care, such as an activity of the JOBS program (see OAR 461-001-0025 and 461-190-0151 to 461-190-0401);

(D) Is paid when the client was not eligible for child care benefits; or

(E) Has given an electronic benefit transfer (EBT) card, card number, or personal identification number (PIN) to a provider for the purpose of checking a child (see OAR 461-001-0000) in or out from the provider's child care.

(d) A misappropriated payment when a person cashes and retains the proceeds of a check from the Department on which that person is not the payee and the check has not been lawfully endorsed or assigned to the person.

(e) A benefit or service provided for a need when that person is compensated by another source for the same need and the person fails to reimburse the Department when required to do so by law.

(f) A cash benefit received by an individual in the GA or SFPSS programs for each month for which the client receives a retroactive SSI lump sum payment.

(g) In the TA-DVS program, a payment made by the Department to an individual or on behalf of an individual when the individual intentionally and without intimidation or coercion by an abuser:

(A) Makes a false or misleading statement or misrepresents, conceals, or withholds information for the purpose of establishing eligibility (see OAR 461-001-0000) for or receiving a benefit from the TA-DVS program; or

(B) Commits any act intended to mislead or misrepresent, conceal, or withhold information for the purpose of establishing eligibility for or receiving a benefit from the TA-DVS program.

(2) The Department may establish an overpayment for the initial month (see OAR 461-001-0000) of eligibility under circumstances including, but not limited to:

(a) The filing group (see OAR 461-110-0310), ineligible student, or authorized representative (see OAR 461-115-0090) withheld information;

(b) The filing group, ineligible student, or authorized representative provided inaccurate information;

(c) The Department failed to use income reported as received or anticipated in determining the benefits of the filing group; or

(d) The error was due to an error in computation or processing by the Department.

(3) In the OCCS Medical programs, the Department may establish an overpayment for the budget month (see OAR 410-200-0015) when the OCCS medical program household group (see OAR 410-200-0015) or authorized representative (see OAR 410-200-0015) withheld or provided inaccurate information.

(4) Overpayments are categorized as follows:

(a) An administrative error overpayment is an overpayment caused by any of the following circumstances:

(A) The Department fails to reduce, suspend, or end benefits after timely reporting by the filing group, OCCS medical program household group, ineligible student, or authorized representative (see OAR 461-115-0090 and 410-200-0015) of a change covered under OAR 461-170-0011 or 410-200-0235 and that reported change requires the Department to reduce, suspend, or end benefits;

(B) The Department fails to use the correct benefit standard;

(C) The Department fails to compute or process a payment correctly based on accurate information timely provided by the filing group, OCCS medical program household group, ineligible student, or authorized representative;

(D) In the GA and SFPSS programs, the Department fails to require a client to complete an interim assistance agreement; or

(E) The Department commits a procedural error that was no fault of the filing group, OCCS medical program household group, ineligible student, or authorized representative.

(b) A client error overpayment is any of the following:

(A) An overpayment caused by the failure of a filing group, OCCS medical program household group, ineligible student, or authorized representative to declare or report information or a change in circumstances as required under OAR 461-170-0011 or 410-200-0235, including information available to the Department, that affects the client's eligibility to receive benefits or the amount of benefits.

(B) A client's unreduced liability or receipt of unreduced benefits pending a contested case hearing decision or other final order favorable to the Department.

(C) A client's failure to return a benefit known by the client to exceed the correct amount.

(D) A client's use of a JOBS or SFPSS program support payment (see OAR 461-190-0211) for other than the intended purpose.

(E) A payment for child care when the client was not engaged in an activity that made the client eligible for child care, such as an activity of the JOBS program (see OAR 461-001-0025 and 461-190-0151 to 461-190-0401).

(F) A payment for child care when the client was not eligible for child care benefits.

(G) The failure of a client to pay his or her entire share of the cost of services or the participant fee (see OAR 461-160-0610 and 461-160-0800) in the month in which it is due.

(H) An overpayment caused by a client giving an electronic benefit transfer (EBT) card, card number, or personal identification number (PIN) to a provider for the purpose of checking a child in or out from the provider's child care.

(I) In the REF, SFPSS, and TANF programs, an overpayment caused by the client using or accessing cash benefits in any electronic benefit transaction in any liquor store; casino, gambling, or gaming establishment; or retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment (see OAR 461-165-0010).

(c) A fraud overpayment is an overpayment determined to be an intentional program violation (see OAR 461-195-0601 and 461-195-0611) or substantiated through a criminal prosecution.

(d) In the SNAP program, a provider error overpayment is an overpayment made to a drug or alcohol treatment center or residential care facility that acted as a client's authorized representative.

(e) In the child care program, a provider error overpayment is a payment made by the Department on behalf of a client to a child care provider when:

(A) Paid to an ineligible provider; or

(B) The payment exceeds the amount for which a provider is eligible.

(5) When an overpayment is caused by both an administrative and client error in the same month, the Department determines the primary cause of the overpayment and assigns as either an administrative or client error overpayment.

(6) In the TANF and TA-DVS programs, when an overpayment puts the client at greater risk of domestic violence (see OAR 461-001-0000), the overpayment is waived (see OAR 461-135-1200).

(7) Except as provided in section (8) of this rule, the Department establishes an overpayment when the following thresholds are exceeded:

(a) Administrative error overpayments concerning:

(A) Cash and child care programs, when the amount is greater than $200;

(B) SNAP open case, when the amount is greater than $100; and

(C) SNAP closed case, when the amount is greater than $200.

(b) Client error overpayments in:

(A) Cash and child care programs, when the amount is greater than $200;

(B) SNAP open case, when the amount is greater than $100;

(C) SNAP closed case, when the amount is greater than $200;

(D) Medical programs, when the amount is greater than $750.

(c) Provider error overpayments in:

(A) Cash and child care programs, when the amount is greater than $200;

(B) SNAP open case, when the amount is greater than $100;

(C) SNAP closed case, when the amount is greater than $200.

(8) There are no overpayment thresholds in all of the following situations:

(a) In SNAP program, if the overpayment was identified in a quality control review.

(b) In all programs, if the overpayment was caused by a client's receipt of continuing benefits in a contested case.

(c) In all programs, if the overpayment was caused by possible fraud by a client or provider.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.081, 411.404, 411.816, 412.001, 412.014, 412.049, HB 2089 (2013, Section 10)

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.081, 411.117, 411.404, 411.620, 411.640, 411.690, 411.816, 411.892, 412.001, 412.014, 412.049, 414.025, 416.350

Hist.: AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 7-2001(Temp), f. & cert. ef. 4-4-01 thru 6-30-01; AFS 12-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 15-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; 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 7-2013(Temp), f. & cert. ef. 3-25-13 thru 9-21-13; SSP 23-2013, f. & cert. ef. 9-20-13; SSP 36-2013(Temp), f. & cert. ef. 11-1-13 thru 4-30-14; SSP 9-2014, f. & cert. ef. 4-1-14; SSP 19-2015, f. & cert. ef. 7-1-15; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16

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Rule Caption: Amending rules relating to public and medical assistance programs
Adm. Order No.: SSP 24-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Amended: 461-120-0330, 461-125-0370, 461-135-0835, 461-145-0380, 461-160-0620
Rules Repealed: 461-125-0370(T)
Subject: OAR 461-120-0330 about the requirement to pursue assets is being amended to align with federal policy regarding converting pension and retirement plans to monthly income if eligible. The rule currently states that individuals must pursue assets to which one has a legal claim or right; however it does not address situations in which one has a legal right to pursue a source of income from an existing resource. This amendment clarifies that individuals must pursue (i.e. set up) monthly payments or distributions from a pension or retirement fund if eligible to do so.

OAR 461-125-0370 about disability as the basis of need is being amended to change the eligibility criteria for a pilot project that allows clients to receive free assistance from the Department with Social Security disability applications and appeals. Under the previous rule, to qualify, clients must be receiving SNAP benefits. The rule is being amended to eliminate that requirement. (That makes permanent a temporary rule adopted on May 13, 2016.) Additionally, the pilot project is being expanded to all AAA (Area Agency on Aging) and APD (Aging and People with Disabilities) offices in Oregon. Under the amended rule, to receive free assistance through the pilot project, an individual must:

- Have a disability under OAR 461-125-0370(1)(c);
- Receive benefits from one of the OCCS Medical Programs (defined in OAR 461-001-0000); and
- Be served by an AAA or APD office.

OAR 461-135-0835 about limits on estate claims is being amended to state that recovery for medical assistance benefits paid in the time period of October 1, 1993 to July 18, 1995 is limited to probate estates and that recovery of Medicare Part D "clawback" paid after December 31, 2013 is limited to benefits paid to an individual age 55 or older.

OAR 461-145-0380 about pension and retirement plans is being amended to state that in the Oregon Supplemental Income Program (OSIP), the Oregon Supplemental Income Program Medical (OSIPM), and the Qualified Medicare Beneficiary Disabled Worker (QMB-DW) program, if the equity value of a plan is counted as a resource, payments received from the plan are considered the conversion of a recourse and are not counted as income.

OAR 461-160-0620 about income deductions and client liability for long-term care services and waivered services is being amended to update the minimum community spouse income allowance (Minimum Monthly Maintenance Needs Allowance or MMMNA) which is published by the federal government each year. This amendment keeps Oregon in line with current federal standards for Department Medicaid programs and changes to the minimum monthly maintenance allowance under the Spousal Impoverishment laws.
Rules Coordinator: Kris Skaro—(503) 945-6067

461-120-0330
Requirement to Pursue Assets

(1) In all programs, except the ERDC and SNAP programs, an individual must make a good faith effort to obtain any asset (other than support and medical coverage, which are covered in OAR 461-120-0340 and 461-120-0345, respectively) to which the individual has a legal right or claim, except as follows:

(a) A parent (see OAR 461-001-0000) or caretaker relative (see OAR 461-001-0000) who is exempt from participation in the JOBS program is not required to apply for unemployment insurance benefits.

(b) Except as specified by law, an individual applying for or receiving any program benefits from the Department is not required to apply for other programs it administers or for supplemental security income (SSI).

(c) An individual applying for the EA program is required to pursue, obtain, and use an asset only if the asset can be made available in time to meet the emergent need.

(d) An individual is not required to borrow money.

(e) An individual is not required to make a good faith effort to obtain any asset if the individual can show good cause for not doing so. Good cause means a circumstance beyond the ability of the individual to control.

(2) In all programs except the ERDC, SNAP, and medical assistance programs:

(a) The effect of failing to comply with this rule is that everyone in the filing group is ineligible. In addition, when a REF, SFPSS, or TANF program payment ends due to the penalty described in this subsection, eligibility for and the level of SNAP benefits are determined as if the individual were receiving benefits without the effects of this rule.

(b) The penalty provided by subsection (2)(a) of this rule is effective until all members of the filing group comply with the requirements of section (1) of this rule.

(3) In the medical assistance programs:

(a) The requirement to pursue assets includes individuals in the benefit group (see OAR 461-110-0750) applying for monthly or periodic payments from a retirement or pension plan (see OAR 461-145-0380) if the individual is eligible to apply under the terms of the plan.

(A) When an individual can choose a lump sum or an annuity as a payment method for the retirement or pension plan, the individual must choose the annuity.

(B) Where an application has been made for a lump sum withdrawal of the monies on which a potential annuity is based and the benefit source permits the individual to change the individual's decision and apply for the annuity, the individual must pursue the change to be eligible for medical benefits. If the benefit source does not permit such a change, accept the individual's word that the decision is irreversible, absent evidence to the contrary.

(C) An individual is not required to file when only a lump sum payment is available.

(b) An individual is ineligible for benefits if the individual fails to comply with the requirements of this rule.

(c) The penalty provided by section (3)(b) of this rule is effective until the individual complies with the requirements of section (1) of this rule and subsection (a) of this section.

Stat. Auth.: ORS 411.060, 411.070, 411.087, 411.404, 411.706, 411.816, 412.006, 412.014, 412.024, 412.049, 412.124, 414.231

Stats. Implemented: ORS 411.060, 411.070, 411.087, 411.404, 411.706, 411.816, 412.006, 412.014, 412.024, 412.049, 412.124, 414.231

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 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 28-1992, f. & cert. ef. 10-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 30-1996, f. & cert. ef. 9-23-96; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 24-2016, f. 6-29-16, cert. ef. 7-1-16

461-125-0370
Disability as the Basis of Need

(1) In the OSIP and OSIPM programs (except OSIP-EPD and OSIPM-EPD), an individual meets the eligibility requirement to have a disability if the requirements of one of the following subsections are met:

(a) The individual is receiving Social Security Disability Income (SSDI) or Supplemental Security Income (SSI) based on disability. Eligibility continues as long as the individual remains eligible for SSDI or SSI.

(b) The individual was eligible for and received Aid to the Disabled benefits in Oregon in December 1973. These grandfathered cases continue to be eligible as long as they are continuously disabled as defined by Oregon requirements that were in effect in 1973.

(c) The Department has determined the individual meets the listing of impairments found in 20 C.F.R. Part 404, Subpart P, Appendix 1; meets the medical vocational guidelines found in 20 C.F.R. Part 404, Subpart P, Appendix 2 for SSI; or meets the definition of disability in 20 C.F.R. section 404.1505 or 416.905.

(d) The Social Security Administration (SSA) has determined the individual meets the listing of impairments found in 20 C.F.R. Part 404, Subpart P, Appendix 1; meets the medical vocational guidelines found in 20 C.F.R. Part 404, Subpart P, Appendix 2; or meets the definition of disability in 20 C.F.R. section 404.1505 or 416.905.

(2) If the Department finds the individual eligible for OSIPM in the absence of a disability determination by SSA, the individual remains eligible, provided that the individual continues to meet the disability criteria for eligibility for OSIPM, until SSA denies the disability claim in a final administrative decision.

(3) For OSIP and OSIPM, a disability determination made by SSA that is unfavorable to an individual is binding on the Department unless the requirements of at least one of the following subsections are met (see 42 C.F.R. section 435.541(c)(1) and (c)(4)):

(a) SSA made the determination for a reason other than disability.

(b) The individual alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(c) More than 12 months after the most recent SSA determination denying disability, the individual alleges that his or her condition has changed or deteriorated since that SSA determination, and the individual has not made application to SSA based on these allegations.

(d) The individual alleges less than 12 months after the most recent SSA determination denying disability that the condition which SSA evaluated has changed or deteriorated since that SSA determination; and one or both of the following apply:

(A) The individual has requested reconsideration or reopening of the most recent SSA determination denying disability and SSA has declined to consider the new allegations.

(B) It is clear that the individual no longer meets SSI eligibility requirements unrelated to disability status but may satisfy comparable Medicaid eligibility requirements.

(4) If a binding SSA disability determination is not in place, the determination of disability to qualify for OSIPM is made by the Presumptive Medicaid Disability Determination Team (PMDDT), composed of a medical or psychological consultant and another individual who is qualified to interpret and evaluate medical reports, other evidence relating to the individual's physical or mental impairments, and (as necessary) to determine the capacities of the individual to perform substantial gainful activity, as specified in 20 C.F.R. Part 416, Subpart J (see 42 C.F.R. section 435.541(f)(2)).

(5) The Presumptive Medicaid Disability Determination Team (PMDDT) obtains and reviews medical reports and other non-medical evidence pertaining to the individual and the claimed disability. The medical report and non-medical evidence must include diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the SSI program specified in 20 CFR Part 416, Subpart I. The PMDDT then makes a decision about medical eligibility and whether and when a redetermination will be made (see 42 C.F.R. section 435.541(f)(1) and (3)).

(6) In the OSIP-EPD and OSIPM-EPD programs, an individual is disabled (see OAR 461-001-0035) or has a disability (see OAR 461-001-0035) if the individual has a physical or mental impairment, or a combination of these impairments, that meets the definition of disability used by SSA when determining eligibility for SSI or SSDI under 20 C.F.R. Part 404. The determination is made as follows:

(a) A determination by SSA that the individual is disabled or has a disability is accepted by the Department.

(b) If the individual was determined to have a disability by SSA and lost their SSDI eligibility due to their own income, the SSA determination remains effective for one year from the date that the individual loses eligibility for SSDI.

(c) If there is no currently effective SSA determination finding the individual has a disability, the case is referred to the Department's central office for a disability determination (see OAR 461-001-0035) using the standards of 20 C.F.R. Parts 404 and 416 and considering all relevant medical and vocational information.

(d) For OSIPM-EPD, an individual is engaging in substantial gainful activity (SGA, see OAR 461-001-0035) if the earnings of the individual are at or above the EPD Income Standard.

(e) For OSIPM-EPD, any work activity engaged in during the OSIPM-EPD application process or certification period is not evaluated as past relevant work (PRW, see OAR 461-001-0035).

(7) An individual who is served by a branch office (see OAR 461-001-0000) and who has been determined by the Presumptive Medicaid Disability Determination Team (PMDDT) to have a disability (see section (1) of this rule) may receive free assistance from the Department with applications and administrative appeals for Social Security benefits based

on a disability for purposes including, but not limited to, meeting the requirement to pursue assets under OAR 461-120-0330.

(8) An individual may receive free assistance from the Department with applications and administrative appeals for Social Security benefits based on a disability for purposes including, but not limited to, meeting the requirement to pursue assets under OAR 410-200-0220 if the individual:

(a) Is determined to have a disability under subsection (1)(c) of this rule;

(b) Receives benefits from one of the OCCS Medical Programs (see OAR 461-001-0000); and

(c) Is served by an AAA (Area Agency on Aging) or APD (Aging and People with Disabilities) office.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.121, 411.404, 411.706, 411.816, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 410.010, 410.020, 410.070, 411.060, 411.070, 411.121, 411.404, 411.704, 411.706, 411.816, 413.085, 414.685

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1991, f. & cert. ef. 10-1-91; 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; SSP 9-2003(Temp), f. & cert. ef. 4-11-03 thru 6-30-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 22-2004, f. & cert. ef. 10-1-04; 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 20-2014(Temp), f. & cert. ef. 8-1-14 thru 1-28-15; SSP 22-2014(Temp), f. 8-29-14, cert. ef. 9-1-14 thru 1-28-15; SSP 27-2014(Temp), f. & cert. ef. 10-1-14 thru 1-28-15; SSP 31-2014(Temp), f. & cert. ef. 12-8-14 thru 1-28-15; SSP 5-2015, f. & cert. ef. 1-29-15; SSP 26-2015(Temp), f. 9-29-15, cert. ef. 10-5-15 thru 4-1-16; SSP 9-2016(Temp), f. 2-23-16, cert. ef. 3-1-16 thru 4-1-16; SSP 13-2016, f. 3-21-16, cert. ef. 4-1-16; SSP 21-2016(Temp), f. & cert. ef. 5-13-16 thru 11-8-16; SSP 19-2016, f. & cert. ef. 5-10-16; SSP 24-2016, f. 6-29-16, cert. ef. 7-1-16

461-135-0835
Limits on Estate Claims

(1) The Estate Administration Unit is designated and authorized to administer the estate recovery program for the Oregon Health Authority and the Department of Human Services, and to present and file claims for payment. This rule sets out some of these claims.

(2) For the OSIP program (see OAR 461-101-0010):

(a) The amount of any payments or benefits, including overpayments (see OAR 461-195-0501), are a claim against the probate estate (see OAR 461-135-0832) of any deceased recipient.

(b) The claim for correctly paid payments or benefits under OSIP are deferred until the death of the spouse (see OAR 461-001-0000) or domestic partner (see OAR 461-135-0832), if any, of the deceased recipient.

(c) If the deceased recipient has no probate estate, the enforcement of the claim has been deferred, or there are insufficient resources in the probate estate to pay the claim in full, the probate estate of the spouse or domestic partner of the deceased recipient, if any, is charged for any payments or benefits paid under OSIP to the deceased recipient, the spouse, or domestic partner.

(d) The claim for correctly paid payments or benefits under OSIP may not be enforced if the deceased recipient is survived by a child under age 21 (see OAR 461-135-0832), a child with a disability (see OAR 461-135-0832), or a child with a visual impairment (see OAR 461-135-0832); and the child survives to the closing of the probate estate.

(e) Transfers of real or personal property without adequate consideration, by recipients of payments or benefits under OSIP, are voidable and may be set aside under ORS 411.620.

(f) Except when there is a surviving spouse or domestic partner, or a surviving child under age 21, a child with a disability, or a child with a visual impairment, the amount of any payments or benefits provided is a claim against the estate (see OAR 461-135-0832) in any conservatorship proceedings and may be paid pursuant to ORS 125.495.

(3) For General Assistance (see OAR 461-135-0832):

(a) The amounts of any payments or benefits, including overpayments, are a claim against the probate estate of any deceased recipient. The amount includes the state's monthly contribution, paid prior to January 1, 2014, to the federal government for the recipient's Medicare Part D prescription drug coverage.

(b) The claim for correctly paid payments or benefits under the General Assistance program is deferred until the death of the spouse or domestic partner, if any, of the deceased recipient.

(c) If the deceased recipient has no probate estate, the enforcement of the claim has been deferred, or there are insufficient resources in the probate estate to pay the claim in full, then the probate estate of the spouse or domestic partner of the deceased recipient, if any, is charged for any payments or benefits to the deceased recipient, the spouse, or domestic partner.

(d) The claim for correctly paid payments or benefits under the OSIP program may not be enforced if the deceased recipient is survived by a child under age 21, a child with a disability, or a child with a visual impairment; and the child survives to the closing of the probate estate.

(e) Except when there is a surviving spouse or domestic partner, or a surviving child under age 21, a child with a disability, or child with a visual impairment, the amount of any assistance paid is a claim against the estate in any conservatorship proceedings and may be paid pursuant to ORS 125.495.

(4) For Medical Assistance (MA, as defined in OAR 461-135-0832):

(a) In determining the extent of the estate resources subject to the claim of the Department for correctly paid benefits, except as provided in subsection (b) of this section, the Department must disregard resources in an amount equal to the value (see OAR 461-135-0832) 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 MA benefits received after the effective date of the MA eligibility determination in which a qualified partnership policy was considered and approved. The amount of any MA incurred in a prior MA eligibility period where qualified partnership policy benefits were not considered is not subject to the estate resource disregard.

(b) There is no disregard of resources under subsection (a) of this section if the recipient, or the spouse of the recipient, 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 recipient or the recipient's spouse, or exhausted the disregarded resource amount by purchasing things of value to the recipient or the recipient's spouse while either was living.

(c) The amount of any incorrectly paid payments or benefits, excluding an administrative error overpayment (see OAR 461-195-0501), are a claim, against the probate estate of any deceased recipient.

(d) The claim for correctly paid payments or benefits under MA is deferred until the death of the surviving spouse, if any, of the deceased recipient. After the death of a surviving spouse, the deferred claim of the deceased recipient is a claim against the following assets (see OAR 461-135-0832) or their proceeds in the probate estate of the spouse.

(A) For a recipient who died prior to October 1, 2008, the Department has a claim against the probate estate of the spouse for medical assistance (see OAR 461-135-0832) paid to the recipient, but only to the extent that the spouse received property or other assets from the recipient through any of the following:

(i) Probate.

(ii) Operation of law.

(B) For a recipient who dies on or after October 1, 2008, the Department has a claim against the probate estate of the recipient's spouse for medical 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 (see OAR 461-135-0832), 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 for MA of the recipient and the recipient's spouse, or at any time thereafter, whether approved, withdrawn, or denied.

(e) The claim for correctly paid payments or benefits under MA may not be enforced if the deceased recipient is survived by a child under age 21, a child with a disability, or a child with a visual impairment.

(f) For recipients who are not permanently institutionalized (see OAR 461-135-0832):

(A) The amount of any payments or benefits paid prior to October 1, 1993 to or on behalf of a recipient 65 years of age or older are a claim against the probate estate of any deceased recipient.

(B) The amount of any payments or benefits, paid on or after October 1, 1993 and prior to July 18, 1995, to or on behalf of a recipient 55 years of age or older are a claim against the probate estate of any deceased recipient.

(C) The amount of any payments or benefits, paid on or after July 18, 1995 and prior to October 1, 2013, to or on behalf of a recipient 55 years of age or older are a claim against the estate of any deceased recipient. All correctly made payments on or after January 1, 2010 for Medicare cost sharing (see OAR 461-135-0832) are excluded from a claim.

(D) The amount of any payments or benefits, paid October 1, 2013 or later, to or on behalf of a recipient 55 years of age or older, during the time the Department was paying any of the cost of care of the individual in a nursing facility, home and community based care (see OAR 461-001-

0030), or in home services through the State Plan Personal Care Services (see OAR 411-034-0010), are a claim against the estate of any deceased recipient. All correctly made payments on or after January 1, 2010 for Medicare cost sharing are excluded from a claim.

(g) For permanently institutionalized individuals, a claim includes amounts calculated according to subsection (f) of this section and the following:

(A) The amount of any payments or benefits before July 18, 1995 to or on behalf of a recipient who was permanently institutionalized is a claim against the probate estate of the deceased recipient.

(B) The amount of any payments or benefits paid between July 19, 1995 through September 30, 2013 to or on behalf of a recipient who was permanently institutionalized is a claim against the estate of the deceased recipient.

(C) The amount of any payment for services provided in a nursing facility, an intermediate care facility for an individual with intellectual or developmental disabilities, a psychiatric institution, or other medical institution (see OAR 461-135-0832) paid after September 30, 2013 to or on behalf of a recipient who was permanently institutionalized is a claim against the estate of the deceased recipient.

(5) The amount paid, for a recipient age 55 or older, after December 31, 2013, to the federal government for the recipient's Medicare Part D prescription drug coverage is a claim against the estate of the deceased recipient.

(6) For trusts that comply with OAR 461-145-0540(10) and (11), the maximum distribution to the Department is the total of all MA payments or benefits paid to or on behalf of the deceased recipient. Subsections (4)(d) and (4)(e) of this rule do not apply to this section.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 413.042, 413.085, 416.340, 416.350
Stats. Implemented: ORS 93.969, 125.495, 411.404, 411.620, 411.630, 411.708, 411.795, 413.085, 416.310, 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; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 24-2016, f. 6-29-16, cert. ef. 7-1-16

461-145-0380
Pension and Retirement Plans

(1) Pension and retirement plans include the following:

(a) Benefits employees receive only when they retire. These benefits can be disbursed in lump-sum or monthly payments.

(b) Benefits that employees are allowed to withdraw when they leave a job before retirement.

(c) The following retirement plans if purchased by an individual with funds from the plans authorized by section 401 of the Internal Revenue Code of 1986:

(A) Traditional Defined-Benefit Plan.

(B) Cash Balance Plan.

(C) Employee Stock Ownership Plan.

(D) Keogh Plan.

(E) Money Purchase Pension Plan.

(F) Profit-Sharing Plan.

(G) Simple 401(k).

(H) 401(k).

(d) Retirement plans purchased by an individual with funds from plans authorized by section 403 of the Internal Revenue Code of 1986 at subsections (a) or (b).

(e) The following retirement plans and annuities if purchased by an individual with funds from the plans authorized by section 408 of the Internal Revenue Code of 1986 at subsections (a), (b), (c), (k), (p), or (q), or at section 408A:

(A) Individual Retirement Annuity.

(B) Individual Retirement Account (IRA).

(C) Deemed Individual Retirement Account or Annuity under a qualified employer plan.

(D) Accounts established by employers and certain associations of employees.

(E) Simplified Employee Pension (SEP).

(F) Simple Individual Retirement Account (Simple-IRA).

(G) Roth IRA.

(f) The following retirement plans offered by governments, nonprofit organizations, or unions:

(A) 457(b) Plan.

(B) 501(c)(18) Plan.

(C) Federal Thrift Savings Plan under 5 USC 8439.

(g) In all programs except the OSIP, OSIPM, and QMB programs, an annuity purchased by an individual with funds from a plan authorized under subsection (c), (d), or (f) of this section.

(2) An annuity purchased by the spouse (see OAR 461-001-0000) of an individual with funds from a retirement plan described in subsection (1)(e) of this rule is not considered a retirement plan and is treated in accordance with OAR 461-145-0020 and OAR 461-145-0022.

(3) Except as provided in subsection (c) of this section, benefits an individual receives from pension and retirement plans are treated as follows:

(a) Monthly payments are counted as unearned income.

(b) All payments not covered by subsection (a) of this section are counted as periodic income (see OAR 461-001-0000 and 461-140-0110) or lump-sum income (see OAR 461-001-0000 and 461-140-0120).

(c) In the OSIP, OSIPM, and QMB-DW programs, if the equity value (see OAR 461-001-0000) of the pension or retirement plan is counted as a resource under section (4) of this rule, any payments received are considered the conversion of a resource and are not counted as income.

(4) In the OSIP, OSIPM, and QMB-DW programs:

(a) Except for an annuity purchased with funds from a retirement plan described in subsection (1)(e) of this rule:

(A) The equity value of a pension or retirement plan is excluded as a resource if the individual is eligible for monthly or periodic payments under the terms of the plan and has applied for those payments. When an individual is permitted to choose or change a payment option, the individual must select the option that:

(i) Provides payments commencing on the earliest possible date; and

(ii) Completes payments within the actuarial life expectancy, as published in the Periodic Life Table of the Office of the Chief Actuary of the Social Security Administration, of the individual.

(B) The equity value of all pension and retirement plans not covered by paragraph (A) of this subsection that allows an individual to withdraw funds, minus any penalty for withdrawal, is counted as a resource.

(b) The equity value of an annuity purchased with funds from a retirement plan described in subsection (1)(e) of this rule is excluded as a resource if it meets the payout requirements of OAR 461-145-0022(10)(c). Otherwise, the equity value is counted as a resource.

(c) For an individual in a standard living arrangement (see OAR 461-001-0000), pension and retirement plans owned by a non-applying spouse are excluded. Dividends and interest earned on pension funds owned by a non-applying spouse are excluded as income.

(5) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, dividends and interest earned on pension funds owned by a non-applying spouse are excluded as income.

(6) In the SNAP program, the value of retirement accounts identified in sections 401(a), 403(a), 403(b), 408, 408(k), 408(p), 408A, 457(b), or 501(c)(18) of the Internal Revenue Code, or in a Federal Thrift Savings Plan account are excluded resources.

(7) In all programs except the OSIP, OSIPM, QMB, and SNAP programs, the equity value of a pension and retirement plan that allows an individual to withdraw funds before retirement, minus any penalty for early withdrawal, is counted as a resource.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.816, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.816, 412.014, 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 21-1995, f. 9-20-95, cert. ef. 10-1-95; SSP 4-2005, f. & cert. ef. 4-1-05; 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 10-2007, f. & cert. ef. 10-1-07; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 13-2009, f. & cert. ef. 7-1-09; [SSP 21-2009(Temp), f. & cert. ef. 7-29-09 thru 1-25-10; Suspended by SSP 26-2009(Temp), f. & cert. ef. 9-1-09 thru 1-25-10]; Administrative correction 2-19-10; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14 ; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 24-2016, f. 6-29-16, cert. ef. 7-1-16

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 an individual 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 individual 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 $60 personal needs allowance for an individual receiving long-term care services.

(B) A $90 personal needs allowance for an individual 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) For an individual who receives home and community-based care:

(i) Except as provided in subparagraph (ii) of this paragraph, the OSIPM maintenance standard.

(ii) For an individual who receives in-home services, the OSIPM maintenance standard plus $500.

(d) A community spouse (see OAR 461-001-0030) monthly income allowance is deducted from the income of the institutionalized spouse (see OAR 461-001-0030) 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. $2,003 is added to the amount over $601 that is needed to pay monthly shelter expenses for the principal residence of the couple. This sum or $2,980.50 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). If an all-inclusive rate covers items that are not allowable shelter expenses, including meals or housekeeping in an assisted living facility, or the rate includes utilities, to the extent they can be distinguished, these items must be deducted from the all-inclusive rate to determine allowable shelter expenses.

(B) Step 2: Compare maintenance needs allowance with community spouse's countable income. The countable (see OAR 461-001-0000) 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 $2,003. To determine the income allowance of each eligible dependent:

(i) The monthly income of the eligible dependent is deducted from $2,003.

(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 individual and eligible dependents.

(ii) The TANF standard is not reduced by the income of the dependent.

(f) Costs for maintaining a home if the individual 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 individual's dependent.

(h) After taking all the deductions allowed by this rule, the remaining balance is the adjusted income.

(i) The individual's liability is determined as follows:

(A) For an individual receiving home and community-based care (except an individual 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 individual, 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 an individual 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 an individual who is not blind; or

(b) One standard earned income deduction of $85 is made from the earned income for an individual who is blind.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.706, 413.085, 414.065, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.706, 413.085, 414.065, 414.685

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 thu 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; SSP 25-2013, f. & cert. ef. 10-1-13; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 3-2014, f. 1-31-14, cert. ef. 2-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 17-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; SSP 24-2014, f. & cert. ef. 10-1-14; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 21-2015, f. & cert. ef. 7-1-15; SSP 24-2016, f. 6-29-16, cert. ef. 7-1-16

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Rule Caption: Establishing the general assistance project as required by HB 4042 (2016)

Adm. Order No.: SSP 25-2016(Temp)

Filed with Sec. of State: 6-30-2016

Certified to be Effective: 7-1-16 thru 12-27-16

Notice Publication Date:

Rules Amended: 461-001-0000, 461-101-0010, 461-110-0630, 461-110-0750, 461-115-0030, 461-115-0050, 461-115-0071, 461-115-0430, 461-115-0700, 461-120-0030, 461-120-0125, 461-120-0210, 461-120-0315, 461-120-0345, 461-120-0350, 461-120-0510, 461-125-0810, 461-135-0560, 461-135-0700, 461-135-0701, 461-135-0708, 461-135-0950, 461-135-0990, 461-140-0010, 461-140-0040, 461-140-0120, 461-140-0210, 461-140-0242, 461-140-0250, 461-140-0296, 461-140-0300, 461-145-0005, 461-145-0040, 461-145-0050, 461-145-0110, 461-145-0220, 461-145-0230, 461-145-0240, 461-145-0250, 461-145-0259, 461-145-0260, 461-145-0320, 461-145-0330, 461-145-0340, 461-145-0360, 461-145-0365, 461-145-0370, 461-145-0410, 461-145-0420, 461-145-0455, 461-145-0460, 461-145-0470, 461-145-0510, 461-145-0540, 461-145-0600, 461-145-0910, 461-145-0920, 461-145-0930, 461-150-0050, 461-155-0010, 461-155-0020, 461-155-0210, 461-155-0360, 461-155-0580, 461-155-0600, 461-155-0610, 461-155-0620, 461-155-0640, 461-155-0670, 461-160-0010, 461-160-0015, 461-160-0055, 461-160-0060, 461-160-0500, 461-160-0620, 461-165-0030, 461-165-0050, 461-165-0120, 461-170-0011, 461-175-0210, 461-175-0240, 461-175-0310, 461-180-0010, 461-180-0065, 461-180-0070, 461-180-0090, 461-195-0521, 461-195-0541

Rules Suspended: 461-110-0390, 461-125-0510, 461-135-0705

Subject: OAR 461-001-0000 about definitions for chapter OAR 461 is being amended to remove references to the GAM program and remove GA and GAM from the definition of "initial month" since

there is no relationship between disqualifying resource transfers and GA.

OAR 461-101-0010 about program acronyms and overview is being amended to remove GAM and simplify the description of GA.

OAR 461-110-0630 about need groups is being amended to remove GAM and GA. The GA need group will be addressed in OAR 461-135-0600.

OAR 461-110-0750 about benefit groups is being amended to remove GAM and GA. The GA benefit group will be addressed in OAR 461-135-0600.

OAR 461-115-0030 about the date of request is being amended to remove GAM.

OAR 461-115-0050 about when an application must be filed is being amended to specify that an application for OSIPM meets the application requirements for GA.

OAR 461-115-0071 about who must sign the application and complete the application process is being amended to remove GAM.

OAR 461-115-0430 about periodic redeterminations is being amended to remove references to GAM and to clarify that redeterminations must be done at least every 12 months; not necessarily at 12 months.

OAR 461-115-0700 about required verification; GA, GAM, OSIP, OSIPM, and QMB is being amended to remove references to GAM and to remove GA from the resource verification section; resource eligibility for GA does not have to be determined separately from that of OSIPM.

OAR 461-120-0030 about state of residence for an individual in a medical facility is being amended to remove a reference to GAM.

OAR 461-120-0125 about alien status is being amended to remove the section pertaining specifically to GA and GAM. Alien status for GA does not have to be determined separately from that of OSIPM.

OAR 461-120-0210 about the requirement to provide a Social Security number is being amended to remove references to GA and GAM. Enumeration requirements for GA do not have to be determined separately from those of OSIPM.

OAR 461-120-0315 about medical assignment is being amended to remove references to GAM.

OAR 461-120-0345 about clients required to obtain health care coverage and cash medical support to remove references to GAM.

OAR 461-120-0350 about clients excused for good cause from compliance with requirements to pursue child support, health care coverage, and medical support is being amended to remove references to GAM.

OAR 461-120-0510 about age requirements for clients to receive benefits is being amended to remove the section pertaining specifically to GA and GAM. Age requirements for GA will be addressed in OAR 461-135-0700.

OAR 461-125-0810 about using administrative medical examinations is being amended to remove a reference to GA, since a Department disability decision necessary to qualify for GA is not made separately from that needed to establish a basis of need for OSIPM.

OAR 461-135-0560 about fleeing felon and violators or parole, probation, and post prison supervision is being amended to remove references to GA and GAM. This requirement will be addressed in OAR 461-135-0700.

OAR 461-135-0700 about specific requirements for GA and GAM is being amended to remove references to GAM and to incorporate the specific requirements for the new GA program.

OAR 461-135-0701 about the termination of GA and GAM programs October 1, 2005 is being amended to incorporate the return of GA.

OAR 461-135-0708 about criteria for developing a plan for self support OSIP, OSIPM, and QMB is being amended to remove references to GA and GAM. This rule is tied to OSIPM financial eligibility and does not need to be addressed separately for GA.

OAR 461-135-0950 about eligibility for inmates and residents of state hospitals is being amended to remove references to and sections pertaining to GAM.

OAR 461-135-0990 about specific requirements; reimbursements of cost effective, private, or employer sponsored health insurance premiums is being amended to remove references to GAM and OCCS medical programs no longer covered in chapter 461 of the OARs.

OAR 461-140-0010 about assets; income and resources is being amended to remove references to GA and GAM as assets are not treated differently in the GA program as they are in OSIPM.

OAR 461-140-0040 about determining availability of income is being amended to remove references to GA and GAM as income is not evaluated differently for GA than it is for OSIPM.

OAR 461-140-0120 about the availability and treatment of lump sum income is being amended to remove references to GA and GAM. Lump sum income is not treated differently in the GA program as it is in OSIPM.

OAR 461-140-0210 about asset transfer; general information and timelines is being amended to remove references to GA and GAM as asset transfers only affect those receiving long term care.

OAR 461-140-0242 about disqualifying transfer of assets including home is being amended to remove references to GA and GAM as asset transfers only affect those receiving long term care.

OAR 461-140-0250 about determining the uncompensated value of a transferred asset is being amended to remove references to GA and GAM as asset transfers only affect those receiving long term care.

OAR 461-140-0296 about length of disqualification due to an asset transfer is being amended to remove references to GA and GAM as asset transfers only affect those receiving long term care.

OAR 461-140-0300 about adjustments to the disqualification for asset transfer is being amended to remove references to GA and GAM as asset transfers only affect those receiving long term care.

OAR 461-145-0005 about Agent Orange disability benefits is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0040 about burial arrangements and burial funds is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0050 about burial spaces and merchandise is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0110 about domestic volunteer services act is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0220 about homes is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0230 about housing and urban development is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0240 about income producing sales contract is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining spe-

cific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0250 about income producing property is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0259 and OAR 461 145 0260 about Indian (Native American) benefits is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0320 about life insurance is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0330 about loans and interest on loans is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0340 about lodger income is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0360 about motor vehicles is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0365 about national and community services trust act, including AmeriCorps is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0370 about Older Americans Act is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0410 about program benefits is being amended to remove references to GAM.

OAR 461-145-0420 about real property is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0455 about reception and placement grants is being amended to remove references to GA. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0460 about sale of a resource is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0470 about shelter in kind income is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0510 about SSI is being amended to remove references to GA and GAM. The receipt of SSI and how it affects GA is addressed in OAR 461-135-0700.

OAR 461-145-0540 about trusts is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0600 about work related capital assets, equipment, and inventory is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0910 about self employment; general is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0920 about self employment; costs that are excluded to determine countable income is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-145-0930 about self employment; determination of countable income is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-150-0050 about prospective eligibility and budgeting is being amended to remove references to GA and GAM. Financial eligibility for OSIPM must be established prior to determining specific eligibility for GA; therefore, it is not necessary to address how specific assets are treated for GA.

OAR 461-155-0010 about use of payment standards to establish need is being amended to remove a reference to GAM.

OAR 461-155-0020 about pro rated standards; adjusted number in household is being amended to remove a reference to GA since it's unnecessary to distinguish GA recipients from OSIPM recipients — GA recipients must be OSIPM recipients by rule.

OAR 461-155-0210 about payment standards; GA and GAM is being amended to remove references to GAM and establish the new GA program payment standards.

OAR 461-155-0360 about pursuit of cost effective employer sponsored health insurance is being amended to remove references to GAM and OCCS medical program no longer under the jurisdiction of chapter 461 of the OARs.

OAR 461-155-0580 about special need; laundry allowances is being amended to remove references to GAM and to remove a reference to GA since it's unnecessary to distinguish GA recipients from OSIPM recipients — GA recipients must be OSIPM recipients by rule.

OAR 461-155-0600 about special need; home repairs, GA, OSIP, and OSIPM is being amended to remove a reference to GA since it's unnecessary to distinguish GA recipients from OSIPM recipients — GA recipients must be OSIPM recipients by rule.

OAR 461-155-0610 about special need; moving costs, GA, OSIP, and OSIPM is being amended to remove a reference to GA since it's unnecessary to distinguish GA recipients from OSIPM recipients — GA recipients must be OSIPM recipients by rule.

OAR 461 155 0620 about special need; property taxes is being amended to remove a reference to GA since it's unnecessary to distinguish GA recipients from OSIPM recipients — GA recipients must be OSIPM recipients by rule.

OAR 461-155-0640 about special need; restaurant meals is being amended to remove a reference to GAM and a reference to GA since

it's unnecessary to distinguish GA recipients from OSIPM recipients — GA recipients must be OSIPM recipients by rule.

OAR 461-155-0670 about special need; special diet allowance is being amended to remove a reference to GAM and a reference to GA since it's unnecessary to distinguish GA recipients from OSIPM recipients — GA recipients must be OSIPM recipients by rule.

OAR 461-160-0010 about use of resources in determining financial eligibility is being amended to remove a reference to GAM and to remove a reference to GA since it's unnecessary to distinguish GA recipients from OSIPM recipients in regards to financial eligibility — GA recipients must be OSIPM recipients by rule.

OAR 461-160-0015 about resource limits is being amended to remove a reference to GAM and to remove a reference to GA, since it's unnecessary to distinguish GA recipients from OSIPM recipients in regards to financial eligibility — GA recipients must be OSIPM recipients by rule.

OAR 461-160-0055 about medical costs that are deductible is being amended to remove GA and GAM as medical cost deductions only apply to OSIPM in regards to post eligibility treatment of income and SNAP.

OAR 461-160-0060 about use of rounding in calculating benefit amount is being amended to remove a reference to GAM.

OAR 461-160-0500 about use of income to determine eligibility and benefits for GA and GAM is being amended to remove the eligibility determination language, since it will be stated in other rules that OSIPM income methodology is used to determine eligibility for GA. This proposed amendment will also establish the new method for determining GA countable and adjusted income in regards to calculating benefit amounts. The individual's or couple's adjusted income will be subtracted from the appropriate housing assistance payment standard to determine benefits. The PIF and utility payments are not affected by income. References to GAM are also being removed.

OAR 461-160-0620 about income deductions and client liability; long term care services or home and community based care; OSIPM is being amended to remove the section which pertains to GA and GAM. GA benefits are only available to those in standard living arrangements and there is no more GAM program.

OAR 461-165-0030 about concurrent and duplicate program benefits is being amended to clarify that an individual may not receive GA and TANF in the same month as well as remove references to discontinued OCCS medical programs as well as remove references to discontinued OCCS medical programs.

OAR 461-165-0050 about dual payee; when to use is being amended to remove GA since any checks will be paid directly to a landlord; other benefits will be put on an EBT card.

OAR 461-165-0120 about benefits for a client is an acute care setting is being amended to remove a reference to GAM.

OAR 461-170-0011 about changes that must be reported is being amended to remove a reference to GAM.

OAR 461-175-0210 about notice situation; client moved or whereabouts unknown is being amended to remove a reference to GAM.

OAR 461-175-0240 about notice situation; lump sum is being amended to remove GA since lump sum income will only affect GA insofar as it affects OSIPM eligibility. If individuals lose OSIPM because of lump sum income (either in the month received or the month after if it puts the client over the resource limit), the GA closure notice will cite ineligibility for OSIPM as the reason.

OAR 461-175-0310 about notice situation; asset transfer disqualification is being amended to remove references to GA and GAM. Asset transfers only affect long term care benefits.

OAR 461-180-0010 about effective dates; adding a new person to an open case is being amended to remove references to GAM.

OAR 461-180-0065 about effective dates; ending disqualifications is being amended to remove a reference to GAM.

OAR 461-180-0070 about effective dates; initial month benefits is being amended to establish that the effective date will either be the month after eligibility is established.

OAR 461-180-0090 about effective dates; initial month medical benefits is being amended to remove a reference to GAM.

OAR 461-195-0521 about calculation of overpayments is being amended to remove a reference to GAM.

OAR 461-195-0541 about liability for overpayments is being amended to remove a reference to GAM.

OAR 461-110-0390 about GA(M) filing groups is being repealed because GA eligibility is dependent on OSIPM eligibility; therefore, there is no need to address the filing group for GA.

OAR 461-125-0510 about impairment criteria in GA and GAM is being repealed as impairment criteria for GA will not be determined or established separately from that of OSIPM under OAR 461-125-0370(1)(c) and will also be addressed in OAR 461-135-0700.

OAR 461-135-0705 about specific requirements GA, GAM ineligible is being repealed — information about what makes one ineligible for GA will be addressed in OAR 461-135-0700.

The rule text showing proposed changes is available at http://www.dhs.state.or.us/policy/selfsufficiency/ar_temporary.htm.
Rules Coordinator: Kris Skaro—(503) 945-6067

461-001-0000
Definitions for Chapter 461

Defined terms are often italicized throughout this chapter of rules. If a defined term is accompanied by a cross-reference to a rule defining the term, subsequent usages of that term in the same rule refer to the same definition cross-referenced earlier in the rule. In this chapter of rules, unless the context indicates otherwise:

(1) A reference to Division, Adult and Family Services Division (or AFS), Senior and Disabled Services Division (or SDSD), or any other agency formerly part of the Department of Human Services means the Department of Human Services (DHS), except:

(a) The rule in which reference occurs only regulates programs covered by OAR chapter 461.

(b) OCCS medical program eligibility rules are in OAR chapter 410, division 200.

(2) "Address Confidentiality Program" (ACP) means a program of the Oregon Department of Justice, which provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence (see section (25) of this rule), sexual assault, or stalking.

(3) "Adjusted income" means the amount determined by subtracting income deductions from countable (see section (18) of this rule) income (see OAR 461-140-0010). Specific rules on the deductions are in OAR chapter 461, division 160.

(4) "Adoption assistance" means financial assistance provided to families adopting children with special needs. "Adoption assistance" may be state or federally funded. Federal adoption assistance is authorized by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. No. 96-272, 94 Stat. 500 (1980)). State adoption assistance is authorized by ORS 418.330 to 418.335.

(5) "Assets" mean income and resources.

(6) "Basic decision notice" means a decision notice (see section (21) of this rule) mailed no later than the date of action given in the notice.

(7) "Branch office" means any Department or AAA (Area Agency on Aging) office serving a program covered by this chapter of rules.

(8) "Budgeting" means the process of calculating the benefit level.

(9) "Budget month" means the calendar month from which nonfinancial and financial information is used to determine eligibility (see section (28) of this rule) and benefit level for the payment month (see section (50) of this rule).

(10) "Cafeteria plan" means a written benefit plan offered by an employer in which:

(a) All participants are employees; and

(b) Participants may choose, cafeteria-style, from a menu of two or more cash or qualified benefits. In this context, qualified benefits are benefits other than cash that the Internal Revenue Service does not consider part of an employee's gross income. Qualified benefits include, but are not limited to:

(A) Accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance);

(B) Group term life insurance plans (up to $50,000);

(C) Dependent care assistance plans; and

(D) Certain stock bonus plans under section 401(k)(2) of the Internal Revenue Code (but not 401(k)(1) plans).

(11) "Capital asset" means property that contributes toward earning self-employment income, including self-employment income from a microenterprise (see section (43) of this rule), either directly or indirectly. A "capital asset" generally has a useful life of over one year and a value, alone or in combination, of $100 or more.

(12) "Caretaker" means an individual who is responsible for the care, control, and supervision of a child (see section (15) of this rule). The status of "caretaker" ends once the individual no longer exercises care, control, and supervision of the child for 30 days.

(13) "Caretaker relative" means a caretaker (see section 12 of this rule) who meets the requirements of one of the following subsections:

(a) Is one of the following relatives of the dependent child (see section (23) of this rule):

(A) Any blood relative, including those of half-blood, and including first cousins, nephews, or nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.

(B) Stepfather, stepmother, stepbrother, and stepsister.

(C) An individual who legally adopts the child and any individual related to the individual adopting the child, either naturally or through adoption.

(b) Is or was a spouse (see section (63) of this rule) of an individual listed in subsection (a) of this section.

(c) Met the definition of "caretaker relative" under subsection (a) or (b) of this section before the child was adopted (notwithstanding the subsequent adoption of the child).

(14) "Certification period" means the period for which an individual is certified eligible for a program.

(15) "Child" includes natural, step, and adoptive children. The term "child" does not include an unborn.

(a) In the ERDC program, a "child" need not have a biological or legal relationship to the caretaker but must be in the care and custody of the caretaker, must meet the citizenship or alien status requirements of OAR 461-120-0110, and must be:

(A) Under the age of 18; or

(B) Under the age of 19 and in secondary school or vocational training at least half time.

(b) In the GA and OSIP programs, a "child" is an individual under the age of 18.

(c) In the OSIPM and QMB programs, "child" means an unmarried individual living with a parent (see section (49) of this rule) who is:

(A) Under the age of 18; or

(B) Under the age of 22 and attending full-time secondary, postsecondary or vocational-technical training designed to prepare the individual for employment.

(d) In the REF and REFM programs, a "child" is:

(A) An individual under the age of 18; or

(B) An individual who is 18 years of age and attending secondary school full-time or pursuing a GED full-time.

(16) "Community based care" is any of the following:

(a) Adult foster care — Room and board and 24 hour care and services for the elderly or for people with disabilities 18 years of age or older. The care is contracted to be provided in a home for five or fewer clients.

(b) Assisted living facility — A program approach, within a physical structure, which provides or coordinates a range of services, available on a 24-hour basis, for support of resident independence in a residential setting.

(c) In-home Services — Individuals living in their home receiving services determined necessary by the Department.

(d) Residential care facility — A facility that provides residential care in one or more buildings on contiguous property for six or more individuals who have physical disabilities or are socially dependent.

(e) Specialized living facility — Identifiable services designed to meet the needs of individuals in specific target groups which exist as the result of a problem, condition, or dysfunction resulting from a physical disability or a behavioral disorder and require more than basic services of other established programs.

(f) Independent choices — In-Home Services program wherein the participant is given cash benefits to purchase self-directed personal assistance services or goods and services provided pursuant to a written service plan (see OAR 411-030-0020).

(17) "Continuing benefit decision notice" means a decision notice that informs the client of the right to continued benefits and is mailed in time to be received by the date benefits are, or would be, received.

(18) "Countable" means that an available asset (either income or a resource) is not excluded and may be considered by some programs to determine eligibility.

(19) "Cover Oregon" means Oregon Health Insurance Exchange Corporation.

(20) "Custodial parents" mean parents who have physical custody of a child. "Custodial parents" may be receiving benefits as dependent children or as caretaker relatives for their own children.

(21) "Decision notice" means a written notice of a decision by the Department regarding an individual's eligibility for benefits in a program.

(22) "Department" means the Department of Human Services (DHS).

(23) "Dependent child" in the TANF program means the following:

(a) An individual who is not a caretaker relative (see section (13) of this rule) of a child in the household, is unmarried or married but separated, and is under the age of 18, or 18 years of age and a full time student in secondary school or the equivalent level of vocational or technical training; or

(b) A minor parent (see section (45) of this rule) whose parents have chosen to apply for benefits for the minor parent. This does not apply to a minor parent who is married and living with his or her spouse.

(24) "Disability" means:

(a) In the SNAP program, see OAR 461-001-0015.

(b) In the REF, SFPSS, TA-DVS, and TANF programs, for purposes other than determining eligibility:

(A) An individual with a physical or mental impairment that substantially limits the individual's ability to meet the requirements of the program; or

(B) An individual with a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or who is regarded as having such an impairment as defined by the Americans with Disabilities Act (42 USC 12102; 28 CFR 35.104).

(25) "Domestic violence" means the occurrence of one or more of the acts described in subsections (a) to (d) of this section between family members, intimate partners, or household members:

(a) Attempting to cause or intentionally, knowingly, or recklessly causing physical injury or emotional, mental, or verbal abuse.

(b) Intentionally, knowingly, or recklessly placing another in fear of imminent serious physical injury.

(c) Committing sexual abuse in any degree as defined in ORS 163.415, 163.425 and 163.427.

(d) Using coercive or controlling behavior.

(e) As used in this section, "family members" and "household members" mean any of the following:

(A) Spouse;

(B) Former spouse;

(C) Individuals related by blood, marriage (see section (43) of this rule), or adoption;

(D) Individuals who are cohabitating or have cohabited with each other;

(E) Individuals who have been involved in a sexually intimate or dating relationship; or

(F) Unmarried parents of a child.

(26) "Domestic violence shelters" are public or private nonprofit residential facilities providing services to victims of domestic violence. If the facility serves other people, a portion must be used solely for victims of domestic violence.

(27) "Electronic application" is an application electronically signed and submitted through the Internet.

(28) "Eligibility" means the decision as to whether an individual qualifies, under financial and nonfinancial requirements, to receive program benefits.

(29) "Equity value" means fair market value (see section (30) of this rule) minus encumbrances.

(30) "Fair market value" means the amount an item is worth on the open market.

(31) "Family stability" in the JOBS, Pre-TANF, Post-TANF, SFPSS, TA-DVS, and TANF programs means the characteristics of a family that support healthy child development, including parental mental health, drug and alcohol free environment, stable relationships, and a supportive, flexible, and nurturing home environment.

(32) "Family stability activity" in the JOBS, Pre-TANF, Post-TANF, SFPSS, TA-DVS, and TANF programs means an action or set of actions taken by an individual, as specified in a case plan, intended to promote the ability of one or both parents to achieve or maintain family stability (see section (31) of this rule).

(33) "Financial institution" means a bank, credit union, savings and loan association, investment trust, or other organization held out to the public as a place receiving funds for deposit, savings, checking, or investment.

(34) "Homeless" in the ERDC program means lacking a fixed regular and adequate nighttime residence and includes living in an emergency shelter, shared housing with others due to loss of housing or economic hardship, staying in motels, cars, parks, public places, tents, trailers, or other similar settings.

(35) "Income producing property" means:

(a) In all programs except OSIP, OSIPM, and QMB, real or personal property that generates income for the financial group (see OAR 461-110-0530). Examples of "income producing property" are:

(A) Livestock, poultry, and other animals.

(B) Farmland, rental homes (including a room or other space in the home or on the property of a member of the financial group), vacation homes, and condominiums.

(b) In the OSIP, OSIPM, and QMB programs, "income-producing property" means any real or personal property not used in self-employment (see OAR 461-145-0600 and 461-145-0915) that produces income for the financial group. "Income-producing property" includes:

(A) Livestock, poultry, or other animals that produce marketable products sold by the financial group.

(B) Farmland not excluded under OAR 461-145-0220 that is farmed or rented out by the financial group.

(C) Real property other than the home (including vacation homes and condominiums), that is rented out.

(c) In the OSIP, OSIPM, and QMB programs, "income-producing property" does not include:

(A) Rooms or other space for rent in the home (see OAR 461-145-0220).

(B) Livestock, poultry, or other animals kept for resale (see OAR 461-145-0010).

(36) "Initial month" of eligibility means any of the following:

(a) In all programs, the first month a benefit group (see OAR 461-110-0750) is eligible for a program benefit in Oregon after a period during which the group is not eligible.

(b) In all programs except the SNAP program, the first month a benefit group is eligible for a program benefit after there has been a break in the program benefit of at least one full calendar month. If benefits are suspended for one month, that is not considered a break.

(c) In the SNAP program:

(A) The first month for which the benefit group is certified following any period during which they were not certified to participate, except for migrant and seasonal farm workers (see OAR 461-001-0015).

(B) For migrant and seasonal farmworkers, the first month for which the benefit group is certified following any period of one month or more during which they were not certified to participate.

(d) For a new applicant to the OSIP or OSIPM program applying for care in a nonstandard living arrangement (see section (45) of this rule), for the purposes of calculating the correct divisor in OAR 461-140-0296, the month in which the individual would have been eligible had it not been for the disqualifying transfer of assets (see section (5) of this rule).

(e) For a current recipient of the OSIP or OSIPM program receiving or applying for care in a nonstandard living arrangement, for the purpose of calculating the correct divisor in OAR 461-140-0296, the later of the following:

(A) The month the disqualifying transfer occurred.

(B) The month of application for long-term care (see section (40) of this rule) services if the individual would have been eligible had it not been for the disqualifying transfer of assets.

(37) "In-kind income" means income in a form other than money (such as food, clothing, cars, furniture, and payments made to a third party).

(38) "Legally married" means a marriage uniting two individuals according to:

(a) The statutes of the state where the marriage occurred;

(b) Except in the SNAP program, the common law of the state in which the two individuals previously resided while meeting the requirements for common law marriage in that state; or

(c) The laws of a country in which the two individuals previously resided while meeting the requirements for legal or cultural marriage in that country.

(39) "Life estate" means the right to property limited to the lifetime of the individual holding it or the lifetime of some other individual. In general, a "life estate" enables the owner of the "life estate" to possess, use, and obtain profits from property during the lifetime of a designated individual while actual ownership of the property is held by another individual. A "life estate" is created when an individual owns property and then transfers ownership to another individual while retaining, for the rest of the individual's life, certain rights to that property. In addition, a "life estate" is established when a member of the financial group purchases a "life estate" interest in the home of another individual.

(40) "Lodger" means a member of the household group (see OAR 461-110-0210) who:

(a) Is not a member of the filing group (see OAR 461-110-0310); and

(b) Pays the filing group:

(A) In all programs except the OSIP, OSIPM, and QMB programs, for room and board.

(B) In the OSIP, OSIPM, and QMB programs, for room with or without board.

(41) "Long term care" means the system through which the Department provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and state hospitals (Eastern Oregon and Oregon State Hospitals).

(42) "Lump-sum income" means income received too infrequently or irregularly to be reasonably anticipated, or received as a one-time payment. "Lump-sum income" includes:

(a) Retroactive benefits covering more than one month, whether received in a single payment or several payments.

(b) Income from inheritance, gifts, winnings, and personal injury claims.

(43) "Marriage" means the union of two individuals who are legally married (see section (38) of this rule).

(44) "Microenterprise" means a sole proprietorship, partnership, or family business with fewer than five employees and capital needs no greater than $35,000.

(45) "Minor parent" in the ERDC and TANF programs means a parent under the age of 18.

(46) "Nonstandard living arrangement" is defined as follows:

(a) In the GA, OSIP, OSIPM, and QMB programs, an individual is considered to be in a "nonstandard living arrangement" when the individual is applying for or receiving services in any of the following locations:

(A) A nursing facility in which the individual receives long-term care services paid with Medicaid funding, except this subsection does not apply to a Medicare client in a skilled-stay 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.

(D) A community based care (see section (16) of this rule) setting, except a State Plan Personal Care (SPPC) setting is not considered a "nonstandard living arrangement".

(b) In all programs except GA, OSIP, OSIPM, and QMB, "nonstandard living arrangement" means each of the following locations:

(A) Foster care.

(B) Residential Care facility.

(C) Drug or alcohol residential treatment facility.

(D) Homeless or domestic violence shelter.

(E) Lodging house if paying for room and board.

(F) Correctional facility.

(G) Medical institution.

(47) "OCCS" is the Office of Client and Community Services, part of the Medical Assistance Programs under the Oregon Health Authority responsible for OCCS medical program eligibility policy, community outreach, OCCS Medical Program eligibility determinations, and the OHA Customer Service Call Center.

(48) "OCCS Medical Programs" refers to programs for which eligibility policy can be found in OAR chapter 410, division 200, and includes

CEC, CEM, MAA, MAF, EXT, OHP, Substitute Care, BCCTP, and MAGI Medicaid/CHIP programs, including:

(a) MAGI Adult;

(b) MAGI Child;

(c) MAGI Parent or Other Caretaker Relative;

(d) MAGI Pregnant Woman; and

(e) MAGI CHIP.

(49) "Ongoing month" means one of the following:

(a) For all programs except the SNAP program, any month following the initial month (see section (35) of this rule) of eligibility, if there is no break in the program benefit of one or more calendar months.

(b) For the SNAP program, any month in the certification period (see section (14) of this rule) following the initial month of eligibility.

(50) "Parent" for all programs except JPI (see OAR 461-135-1260) and the SNAP program means the biological mother or father of an unborn child or the biological, step, or adoptive mother or father of a child. For JPI and the SNAP program, "parent" means the biological or legal mother or father of an individual.

(a) If the mother lives with a male and either she or the male claims that he is the father of the child or unborn, and no one else claims to be the father, he is treated as the father even if paternity has not been legally established.

(b) A stepparent relationship exists if:

(A) The individual is legally married to the child's biological or adoptive parent; and

(B) The marriage has not been terminated by legal separation, divorce, or death.

(c) A legal adoption erases all prior legal and blood relationships and establishes the adoptive parent as the legal parent. However, the biological parent is also considered a "parent" if both of the following are true:

(A) The child lives with the biological parent; and

(B) The legal parent has given up care, control, and supervision of the child.

(51) "Payment month" means, for all programs except EA, the calendar month for which benefits are issued.

(52) "Payment period" means, for EA, the 30-day period starting with the date the first payment is issued and ending on the 30th day after the date the payment is issued.

(53) "Periodic income" means income received on a regular basis less often than monthly.

(54) "Primary person" for all programs except the SNAP program, means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits. The "primary person" for individual programs is as follows:

(a) For the TANF program, the parent or caretaker relative.

(b) For the ERDC program, the caretaker.

(c) For SNAP, see OAR 461-001-0015.

(d) For the GA, OSIP, OSIPM, QMB, REF, and REFM programs: the client or client's spouse.

(55) "Qualified Partnership Policy" means a long-term care insurance policy meeting the requirements of OAR 836-052-0531 that was either:

(a) Issued while the individual was a resident in Oregon on January 1, 2008 or later; or

(b) Issued in another state while the individual was a resident of that state on or after the effective date of that state's federally approved State Plan Amendment to issue qualified partnership policies.

(56) "Real property" means land, buildings, and whatever is erected on or affixed to the land and taxed as "real property".

(57) "Reimbursement" means money or in-kind compensation provided specifically for an identified expense.

(58) "Safe homes" mean private homes that provide a few nights lodging to victims of domestic violence. The homes must be recognized as such by the local domestic violence agency, such as crisis hot lines and shelters.

(59) "Shelter costs" mean, in all programs except the SNAP program, housing costs (rent or mortgage payments, property taxes) and utility costs, not including cable TV or non-basic telephone charges. In the SNAP program, see OAR 461-160-0420.

(60) "Shelter in kind" means an agency or individual outside the financial group provides the shelter of the financial group, or makes a payment to a third party for some or all of the shelter costs (see section (58) of this rule) of the financial group. "Shelter-in-kind" does not include temporary shelter provided by a domestic violence shelter, homeless shelter, or residential alcohol and drug treatment facilities or situations where no shelter is being provided, such as sleeping in a doorway, park, or bus station.

(61) "Sibling" means the brother or sister of an individual. "Blood related" means they share at least one biological or adoptive parent. "Step" means they are not related by blood, but are related by the marriage of their parents.

(62) "Spousal support" means income paid (voluntarily, per court order, or per administrative order) by a separated or divorced spouse to a member of the financial group.

(63) "Spouse" means an individual who is legally married to another individual.

(64) "Stable income" means income that is the same amount each time it is received.

(65) "Standard living arrangement" means a location that does not qualify as a nonstandard living arrangement.

(66) "Teen parent" means, for TANF and JOBS, a parent under the age of 20 who has not completed a high school diploma or GED.

(67) "Timely continuing benefit decision notice" means a decision notice that informs the individual of the right to continued benefits and is mailed no later than the time requirements in OAR 461-175-0050.

(68) "Trust funds" mean money, securities, or similar property held by an individual or institution for the benefit of another individual.

(69) "USDA meal reimbursements" mean cash reimbursements made by the Oregon Department of Education for family day-care providers who serve snacks and meals to children in their care.

(70) "Variable income" means earned or unearned income that is not always received in the same amount each month.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.006, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.816, 411.837, 412.001, 412.006, 412.014, 412.049, 413.085, 414.685

Hist.: AFS 28-1978, f. & ef. 7-13-78; AFS 54-1984, f. 12-28-84, ef. 1-1-85; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; 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 10-2007, f. & cert. ef. 10-1-07; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 15-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 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 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; Administrative correction 4-21-10; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; 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 22-2013(Temp), f. & cert. ef. 8-23-13 thru 2-19-14; SSP 24-2013, f. & cert. ef. 10-1-13; SSP 29-2013(Temp), f. & cert. ef. 10-1-13 thru 2-19-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 39-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; SSP 9-2014, f. & cert. ef. 4-1-14; SSP 14-2014(Temp), f. & cert. ef. 6-26-14 thru 12-23-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 18-2014(Temp), f. & cert. ef. 7-1-14 thru 12-23-14; SSP 24-2014, f. & cert. ef. 10-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15; SSP 25-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 29-2015(Temp), f. & cert. ef. 10-1-15 thru 3-28-16; SSP 36-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-101-0010
Program Acronyms and Overview

(1) Acronyms are frequently used when referring to a program. There is an acronym for each umbrella program and acronyms for each subprogram.

(2) When no program acronym appears in a rule in chapter 461 of these rules, the rule with no program acronym applies to all programs listed in this rule. If a rule does not apply to all programs, the rule uses program acronyms to identify the programs to which the rule applies.

(3) Wherever an umbrella acronym appears, that means the rule covers all the subprograms under that code.

(4) CAWEM; Citizen/Alien-Waived Emergent Medical. Medicaid coverage of emergent medical needs for individuals who are not eligible for other medical programs solely because they do not meet citizenship and alien status requirements.

(5) DSNAP; Disaster Supplemental Nutrition Assistance Program. Following a presidential declaration of a major disaster in Oregon, DSNAP provides emergency DSNAP program benefits to victims. OAR 461-135-0491 to 461-135-0497 cover DSNAP eligibility and benefits.

(6) EA; Emergency Assistance. Emergency cash to families without the resources to meet emergent needs.

(7) ERDC or ERDC-BAS; Employment Related Day Care-Basic. Helps low-income working families pay the cost of child care.

(8) GA; General Assistance. Cash assistance to certain low-income individuals with disabilities.

(9) HSP; Housing Stabilization Program. A program that helps low-income families obtain stable housing. The program is operated through the Housing and Community Services Department through community-based, service-provider agencies. The Department's rules for the program (OAR 461-135-1305 to 461-135-1335) were repealed July 1, 2001.

(10) JOBS; Job Opportunity and Basic Skills. An employment program for TANF clients. JOBS helps these clients attain self-sufficiency through training and employment. The program is part of Welfare Reform.

(11) JOBS Plus. Provides subsidized jobs rather than SNAP or TANF benefits. For TANF clients, JOBS Plus is a component of the JOBS Program; for SNAP clients and noncustodial parents of children receiving TANF, it is a separate employment program. Eligibility for TANF clients, SNAP clients, and noncustodial parents of children receiving TANF is determined by the Department. Eligibility for UI recipients is determined by the Oregon State Employment Department. When used alone, JOBS Plus includes only clients whose JOBS Plus program participation is through the Department of Human Services. JOBS Plus administered through the Oregon State Employment Department is known in chapter 461 of the Oregon Administrative Rules as Oregon Employment Department UI JOBS Plus. The following acronyms are used for specific categories:

(a) TANF-PLS; Clients eligible for JOBS Plus based on TANF.

(b) SNAP-PLS; Clients eligible for JOBS Plus based on SNAP.

(c) NCP-PLS; Noncustodial parents of children receiving TANF.

(12) JPI; Job Participation Incentive. An additional $10 food benefit to help increase the ability of parents with children, who meet federal TANF participation rate, to meet the nutritional needs of their families.

(13) LIS; Low-Income Subsidy. The Low-Income Subsidy program is a federal assistance program for Medicare clients who are eligible for extra help meeting their Medicare Part D prescription drug costs.

(14) OFSET. The Oregon Food Stamp Employment Transition Program, which helps SNAP program benefit recipients find employment. This program is mandatory for some SNAP program benefit recipients.

(15) OSIP; Oregon Supplemental Income Program. Cash supplements and special need payments to individuals who are blind, disabled, or 65 years of age or older. When used alone, OSIP refers to all OSIP programs. The following acronyms are used for OSIP subprograms:

(a) OSIP-AB; Oregon Supplemental Income Program — Aid to the Blind.

(b) OSIP-AD; Oregon Supplemental Income Program — Aid to the Disabled.

(c) OSIP-EPD; Oregon Supplemental Income Program — Employed Persons with Disabilities program. This program provides Medicaid coverage for employed persons with disabilities with adjusted income less than 250 percent of the Federal Poverty Level.

(d) OSIP-OAA; Oregon Supplemental Income Program — Old Age Assistance.

(16) OSIPM; Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals. When used alone, OSIPM refers to all OSIP-related medical programs. The following codes are used for OSIPM subprograms:

(a) OSIPM-AB; Oregon Supplemental Income Program Medical — Aid to the Blind.

(b) OSIPM-AD; Oregon Supplemental Income Program Medical — Aid to the Disabled.

(c) OSIPM-EPD; Oregon Supplemental Income Program Medical — Employed Persons with Disabilities program. This program provides Medicaid coverage for employed persons with disabilities with adjusted income less than 250 percent of the Federal Poverty Level.

(d) OSIPM-OAA; Oregon Supplemental Income Program Medical — Old Age Assistance.

(e) OSIPM-IC; Oregon Supplemental Income Program Medical — Independent Choices

(17) The Post-TANF program provides a monthly transitional payment to employed clients who are no longer eligible for the Pre-TANF or TANF programs due to earnings, and meet the other eligibility requirements.

(18) The Pre-TANF program is an up-front assessment and resource-search program for TANF applicant families. The intent of the program is to assess the individual's employment potential; determine any barriers to employment or family stability; develop an individualized case plan that promotes family stability and financial independence; help individuals find employment or other alternatives; and provide basic living expenses immediately to families in need.

(19) QMB; Qualified Medicare Beneficiaries. Programs providing payment of Medicare premiums and one program also providing additional medical coverage for Medicare recipients. Each of these programs also is considered to be a Medicare Savings Program (MSP). When used alone in a rule, QMB refers to all MSP. The following codes are used for QMB subprograms:

(a) QMB-BAS; Qualified Medicare Beneficiaries — Basic. The basic QMB program.

(b) QMB-DW; Qualified Medicare Beneficiaries — Disabled Worker. Payment of the Medicare Part A premium for individuals under age 65 who have lost eligibility for Social Security disability benefits because they have become substantially gainfully employed.

(c) QMB-SMB; Qualified Medicare Beneficiaries — Specified Limited Medicare Beneficiary. Payment of the Medicare Part B premium only. There are no medical benefits available through QMB-SMB.

(d) QMB-SMF; Qualified Medicare Beneficiaries — Qualified Individuals. Payment of the Medicare Part B premium only. There are no medical benefits available through QMB-SMF. This program has a 100-percent federal match, but also has an allocation that, if reached, results in the closure of the program.

(20) REF; Refugee Assistance. Cash assistance to low-income refugee singles or married couples without children.

(21) REFM; Refugee Assistance Medical. Medical coverage for low-income refugees.

(22) The Repatriate Program helps Americans resettle in the United States if they have left a foreign land because of an emergency situation.

(23) SFDNP; Senior Farm Direct Nutrition Program. Food vouchers for low-income seniors. Funded by a grant from the United States Department of Agriculture.

(24) SFPSS; State Family Pre-SSI/SSDI Program. A voluntary program providing cash assistance and case management services to families when at least one TANF eligible adult in the household has an impairment (see OAR 461-125-0260) and is or will be applying for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

(25) SNAP; Supplemental Nutrition Assistance Program. Helps low-income households maintain proper nutrition by giving them the means to purchase food. SNAP used to be known as FS or Food Stamps; any reference to SNAP also includes FS and Food Stamps.

(26) TA-DVS; Temporary Assistance for Domestic Violence Survivors. Addresses the needs of individuals threatened by domestic violence.

(27) TANF; Temporary Assistance for Needy Families. Cash assistance for families when children in those families are deprived of parental support because of continued absence, death, incapacity, or unemployment.

Stat. Auth.: ORS 411.060, 411.404, 411.706, 411.816, 412.014, 412.049, 414.025 & 414.826
Stats. Implemented: ORS 411.060, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 414.025, 414.826 & 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 16-1990, f. 6-29-90, cert. ef. 7-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 16-1993, f. & cert. ef. 9-1-93; 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 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 17-1996, f. 4-29-96, cert. ef. 5-1-96; 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 9-1997, f. & cert. ef. 7-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 25-1998, f. 12-18-98, cert. ef. 1-1-99; 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 9-1999, f. & cert. ef. 7-1-99; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; AFS 17-2001(Temp), f. 8-31-01, cert. ef. 9-1-01 thru 9-30-01; 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 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 7-2003, f. & cert. ef. 4-1-03; 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 17-2004, f. & cert. ef. 7-1-04; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 8-2006, f. & cert. ef. 6-1-06; 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 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; 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 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 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 22-2013(Temp), f. & cert. ef. 8-23-13 thru 2-19-14; SSP 29-2013(Temp), f. & cert. ef. 10-1-13 thru 2-19-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 14-2014(Temp), f. & cert. ef. 6-26-14 thru 12-23-14; SSP 16-2014, f. & cert. ef. 7-1-1; SSP 18-2014(Temp), f. & cert. ef. 7-1-14 thru 12-23-14; SSP 24-2014, f. & cert. ef. 10-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-110-0390
Filing Group; GA, GAM

In the GA and GAM programs, the filing group consists of the applicant and the applicant's spouse (see OAR 461-001-0000).

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 19-1993, f. & cert. ef. 10-1-93; 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 10-2011, f. 3-31-11, cert. ef. 4-1-11; Suspended by SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-110-0630
Need Group

(1) The "need group" consists of the individuals whose basic and special needs are used in determining eligibility (see OAR 461-001-0000) and benefit level.

(2) In the EA, REF, and REFM programs, the need group consists of the members of the financial group (see OAR 461-110-0530) who meet all nonfinancial eligibility requirements, except that members disqualified for an intentional program violation (see OAR 461-195-0601) are not in the need group.

(3) In the ERDC, OSIPM-EPD, and QMB programs, the need group consists of each member of the financial group.

(4) In the OSIPM (except OSIPM-EPD) program:

(a) If a child (see OAR 461-001-0000) is applying, the need group consists of the child.

(b) In all other situations, the need group consists of each member of the financial group.

(5) In the Pre-TANF and TANF programs, the need group consists of all the members of the financial group except:

(a) A parent (see OAR 461-001-0000) who is in foster care and for whom foster care payments are being made.

(b) An unborn child.

(6) In the SNAP program, the need group consists of the members of the financial group who meet all nonfinancial eligibility requirements, except the following individuals are not in the need group:

(a) A member disqualified for an intentional program violation.

(b) A fleeing felon under OAR 461-135-0560.

(c) An individual violating a condition of state or federal parole, probation, or post-prison supervision under OAR 461-135-0560.

(d) An individual who becomes ineligible due to the time limit in OAR 461-135-0520.

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, 412.049, 414.025, 414.231, 414.826, 414.831 & 414.839
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 6-1991(Temp), f. & cert. ef. 2-8-91; AFS 13-1991, f. & cert. ef. 7-1-91; 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 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; 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 9-1997, f. & cert. ef. 7-1-97; 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 17-2004, f. & cert. ef. 7-1-04; SSP 6-2006, f. 3-31-06, cert. ef. 4-1-06; 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 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; 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 17-2008, f. & cert. ef. 7-1-08; SSP 13-2009, f. & cert. ef. 7-1-09; 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 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 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 16-2012(Temp), f. & cert. ef. 5-1-12 thru 10-28-12; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-110-0750
Benefit Group

(1) A "benefit group" consists of the individuals who receive benefits.

(2) Except as provided in sections (4) and (5) of this rule, for an individual not assumed eligible for medical programs (see OAR 461-135-0010), the benefit group consists of each individual from the need group (see OAR 461-110-0630) requesting benefits who meets all financial and nonfinancial eligibility (see OAR 461-001-0000) requirements.

(3) For an individual assumed eligible for medical programs (see OAR 461-135-0010), the benefit group consists of the individuals who are in the benefit group of the program used to assume eligibility.

(4) In the TANF program, the following individuals are not in the benefit group:

(a) An individual who may not be in the benefit group because of a disqualification penalty (see OAR 461-130-0330 and 461-135-0085).

(b) An individual disqualified for an intentional program violation (see OAR 461-195-0601).

(c) An individual who may not be in the benefit group because the individual has reached the time limit in OAR 461-135-0071 and does not meet any of the extension criteria in OAR 461-135-0073 or exemption criteria in OAR 461-135-0075.

(d) A fleeing felon (see OAR 461-135-0560).

(e) An individual violating a condition of state or federal parole, probation, or post-prison supervision (see OAR 461-135-0560).

(f) An individual who does not meet the citizenship and alien status requirements in OAR 461-120-0110 and 461-120-0125.

(g) An individual who chooses not to receive benefits.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.404, 411.816, 412.014, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; 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 8-2006, f. & cert. ef. 6-1-06; SSP 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-115-0030
Date of Request

(1) For all programs covered by OAR chapter 461, an individual or someone authorized to act on behalf of an individual must contact the Department or use another appropriate method to request benefits (see OAR 461-115-0150). The request may be oral or in writing. The request starts the application process.

(2) The "date of request" is one of the following:

(a) In the EA, ERDC, GA, OSIP, REF, and TANF programs and for support service payments in the JOBS program authorized by OAR 461-190-0211, the "date of request" is the day the request for benefits is received by the Department.

(b) In the SNAP program, this section does not apply. See OAR 461-115-0040.

(c) In the OSIPM, QMB, and REFM programs, for a new applicant, the "date of request" is determined as follows:

(A) The day the request for medical benefits is received by a Department representative, except as described in paragraph (B) of this subsection.

(B) If the request for medical benefits is received by a Department representative no later than the next business day after medical services are received, the "date of request" is the day these medical services were received.

(d) In the OSIPM, QMB, and REFM programs, for a current recipient, the "date of request" is one of the following:

(A) The date the individual reports a change requiring a redetermination of eligibility (see OAR 461-001-0000).

(B) The date the Department initiates a review.

(C) The date the individual establishes a "date of request" by contacting the Department orally or in writing or by submitting an application.

(e) In the SFPSS program:

(A) Except as provided in paragraph (B) of this subsection, the "date of request" is the day the individual signs the Interim Assistance Agreement.

(B) The "date of request" for support service payments is the day the request for benefits is received by the Department.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685, 414.826, 414.839
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 413.085, 414.041, 414.685, 414.826, 414.839
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; 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 28-1992, f. & cert. ef. 10-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; AFS 5-2000, f. 2-29-00, cert. ef. 3-1-00; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 21-2004, f. & cert. ef. 10-1-04; 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 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 12-2008(Temp), f. & cert. ef. 4-17-08 thru 6-30-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 22-2009(Temp), f. & cert. ef. 8-28-09 thru 2-21-10; 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 23-2011(Temp), f. & cert. ef. 8-1-11 thru 1-27-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 17-2015, f. & cert. ef. 6-30-15; SSP 22-2015(Temp), f. & cert. ef. 7-23-15 thru 1-18-16; SSP 28-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-115-0050
When an Application Must Be Filed

(1) An individual must file an application, or may amend a completed application, as a prerequisite to receiving benefits as follows:

(a) An individual may apply for the GA program by completing an application for OSIPM.

(b) An individual may apply for the TA-DVS program as provided in OAR 461-135-1220.

(c) In all programs except the TA-DVS program:

(A) Except as provided otherwise in this rule, to apply for program benefits, an individual must submit a complete application on a form approved by the Department.

(B) An application is complete if all of the following requirements are met:

(i) All information necessary to determine eligibility (see OAR 461-001-0000) and benefit amount is provided on the application for each individual in the filing group (see OAR 461-110-0310).

(ii) The applicant, even if homeless, provides a valid mailing address.

(iii) The application is signed by the individual, the authorized representative (see OAR 461-115-0090 and 461-115-0140) of the individual, or another individual applying for benefits on behalf of the individual, and received by the Department.

(I) An individual required but unable to sign the application may sign with a mark, witnessed by another individual.

(II) An individual submitting an electronic application (see OAR 461-001-0000) must submit the application with an electronic signature.

(2) A new application is not required in the following situations:

(a) In the GA program, when an individual is receiving OSIPM on the date of request (see OAR 461-115-0030) for GA.

(b) In the SNAP program, when a single application can be used both to determine an individual is ineligible in the month of application and to determine the individual is eligible the next month. This may be done when;

(A) Anticipated changes make the filing group (see OAR 461-110-0370) eligible the second month; or

(B) The filing group provides verification between 30 and 60 days following the filing date (see OAR 461-115-0040), under OAR 461-180-0080.

(c) In all programs except the SNAP program, when a single application can be used both to determine an individual is ineligible on the date of request (see OAR 461-115-0030) and to determine the individual is eligible when anticipated changes make the filing group eligible within 45 days from the date of request.

(d) When the case is closed and reopened during the same calendar month.

(e) When benefits were suspended for one month because of the level of income, and the case is reopened the month following the month of suspension.

(f) When reinstating medical benefits for a pregnant woman covered by OAR 461-135-0950, notwithstanding subsection (g) of this section.

(g) In the ERDC program, when a case closed during the certification period (see OAR 461-001-0000) and the individual reports a change in circumstances prior to the end of the month following the closure and the reported change will make the individual eligible.

(h) In the OSIPM and QMB programs, when the medical benefits of an individual are suspended because the individual lives in a public institution (see OAR 461-135-0950), if the inmate is released within 12 months of admission and the inmate provides notification to the Department within 10 days of the release.

(3) When an individual establishes a new date of request prior to the end of the month following the month of case closure, unless the Department determines a new application is required, a new application is not required in the following situations:

(a) In the OSIPM program, when the individual's case closed due to failure to make a liability payment required under OAR 461-160-0610.

(b) In the OSIPM-EPD program, when the individual's case closed due to failure to make a participant fee payment required under OAR 461-160-0800.

(4) A new application is required to add a newborn child (see OAR 461-001-0000) to a benefit group (see OAR 461-110-0750) according to the following requirements:

(a) In the ERDC and SNAP programs, an application is not required to add the child to the benefit group.

(b) In the OSIPM, QMB, and REFM programs, an additional application is not required to add an assumed eligible newborn (see OAR 461-135-0010) to a benefit group currently receiving Department medical program benefits.

(c) In the TANF program:

(A) A new application is not required if the child is listed on the application as "unborn" and there is sufficient information about the child to establish its eligibility.

(B) A new application is required if the child is not included on the application as "unborn."

(d) In all programs other than ERDC, QMB, REF, REFM, SNAP, and TANF, an application is required.

(5) A new application is required to add an individual, other than a newborn child, to a benefit group according to the following requirements:

(a) In the ERDC and SNAP programs, a new application is not required.

(b) In the REF, REFM, and TANF programs, an individual may be added by amending a current application if the information is sufficient to determine eligibility; otherwise a new application is required.

(c) In all programs other than the ERDC, REF, REFM, SNAP, and TANF programs, a new application is required.

(6) An individual whose TANF grant is closing may request ERDC orally or in writing.

(7) Except for an applicant for the OSIPM, QMB, or SNAP program, an individual may change between programs administered by the Department using the current application if the following conditions are met:

(a) The individual makes an oral or written request for the change.

(b) The Department has sufficient evidence to determine eligibility and benefit level for the new program without a new application.

(c) The program change can be effected while the individual is eligible for the first program.

(8) In the OSIP, OSIPM, and QMB programs, a new application is not required to redetermine eligibility if the following conditions are met:

(a) The individual is currently receiving benefits from one of these programs.

(b) The Department has sufficient evidence to redetermine eligibility for the same program or determine eligibility for the new program without a new application or by amending the current application.

Stat. Auth: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.049, 413.085, 414.025, 414.685

Stats. Implemented: ORS 409.050, 411.060, 411.070, 411.117, 411.404, 411.704, 411.706, 411.816, 412.049, 413.085, 414.025, 414.041, 414.231, 414.685, 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 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 3-1991(Temp), f. & cert. ef. 1-17-91; AFS 13-1991, f. & cert. ef. 7-1-91; 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 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 27-1996, f. 6-27-1996, cert. ef. 7-1-96; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 5-1998(Temp), f. & cert. ef. 3-11-98 thru 5-31-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; AFS 21-2001(Temp), f. & cert. ef. 10-1-01 thru 12-31-01; AFS 22-2001, f. & cert. ef. 10-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 2-2008(Temp), f. & cert. ef. 1-28-08 thru 6-30-08; 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 17-2009(Temp), f. 7-29-09, cert. ef. 8-1-09 thru 1-28-10; SSP 22-2009(Temp), f. & cert. ef. 8-28-09 thru 1-28-10; 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 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 19-2013(Temp), f. 7-31-13, cert. ef. 8-1-13 thru 1-28-14; SSP 28-2013(Temp), f. & cert. ef. 10-1-13 thru 1-28-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 28-2014(Temp), f. & cert. ef. 10-29-14 thru 4-26-15; SSP 16-2015, f. & cert. ef. 4-1-15; SSP 24-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-115-0071

Who Must Sign the Application and Complete the Application Process

(1) In the ERDC and TANF programs, the following individuals must sign the application and complete the application process:

(a) In the ERDC program, a caretaker (see OAR 461-001-0000).

(b) In the TANF program, at least one caretaker relative (see OAR 461-001-0000).

(2) In the EA program:

(a) A caretaker relative must sign the application and complete the application process for a child (see OAR 461-001-0000). If the child is not living with a caretaker relative, another adult may act on behalf of the child.

(b) If the caretaker relative lives with a spouse (see OAR 461-001-0000), both must sign the application.

(c) A dependent child 18 years of age who applies must sign the application and complete the application process.

(3) In the GA, OSIPM, and QMB programs, at least one adult requesting assistance must complete the application process and sign the application, if able. If there is no adult who is able to sign the application and complete the application process, this may be done by the authorized representative (see OAR 461-115-0090). If the applicant dies prior to the determination of eligibility for OSIPM, the application may be processed if the Department receives the required verification.

(4) In the REF and REFM programs, at least one adult member of the filing group (see OAR 461-110-0430) must sign the application.

(5) In the SNAP program, the primary person (see OAR 461-001-0015), the spouse of the primary person, or another adult member of the filing group (see OAR 461-110-0370) must sign the application and complete the application process.

(6) An individual required to sign the application but unable to sign may sign with a mark, witnessed by an employee of the:

(a) Branch office (see OAR 461-001-0000); or

(b) Public institution (see OAR 461-135-0950), when the individual applying is an inmate (see OAR 461-135-0950) and is applying for benefits under the OSIPM program.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.081, 411.087, 411.400, 411.404, 411.816, 412.049
Hist.: 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 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 23-2010(Temp), f. & cert. ef. 7-15-10 thru 1-11-11; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 19-2014(Temp), f. & cert. ef. 7-16-14 thru 1-12-15; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 24-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-115-0430
Periodic Redeterminations; Not EA, ERDC, SNAP, or TA-DVS

The Department periodically redetermines the eligibility (see OAR 461-001-0000) 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 GA program, the Department redetermines eligibility at least once every 12 months.

(2) 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.

(3) 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 OSIPM, a redetermination for QMB is completed with the redetermination of OSIPM.

(4) The REF and REFM programs are time limited programs; therefore, no periodic redeterminations are made.

(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, 413.085, 414.685, 414.826, 414.839
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 412.014, 412.049, 413.085, 414.685, 414.826, 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; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 24-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-115-0700
Required Verification; GA, GAM, OSIP, OSIPM, QMB

In the GA, OSIP, OSIPM, and QMB programs:

(1) Except as provided in section (2) of this rule, all eligibility (see OAR 461-001-0000) factors must be verified at initial application, when there is a change to any factor, and whenever eligibility for benefits becomes questionable.

(2) In the OSIP, OSIPM, and QMB-DW programs, if the total reported value of gross "liquid resources" of the financial group (see OAR 461-110-0530) is less than $400, verification of the value of "liquid resources" is only required if questionable. For the purposes of this rule, "liquid resources" include cash as well as other resources that can be converted to cash within 20 business days, except that the cash surrender value of a life insurance policy is not considered a liquid resource.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 413.085, 414.685
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.706, 413.085, 414.685, 414.839
Hist.: AFS 19-1993, f. & cert. ef. 10-1-93; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 25-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-120-0030
State of Residence for an Individual in a Medical Facility

In the OSIPM, QMB, and REFM programs, the residency of an individual living in a state or private medical facility such as a hospital, mental hospital, nursing home, or convalescent center is determined as follows:

(1) An individual 21 years of age or older who is capable of indicating intent to reside is considered to be;

(a) A resident of the state where the individual is living with the intention to remain permanently or for an indefinite period, except when subsection (b) of this section indicates otherwise.

(b) When a state agency of another state places the individual (other than a child funded under Title IV-E), the individual is considered to be a resident of the state that makes the placement.

(2) An individual 21 years of age or older who became incapable of indicating intent to reside after attaining 21 years of age is considered to be a resident of the state where the facility is located unless the individual was placed in the facility by a state agency of another state. When a state agency of another state places an individual, the individual is considered to be a resident of the state that makes the placement.

(3) For an individual less than 21 years of age who is incapable of forming an intent to reside, or an individual of any age who became incapable of forming that intent before attaining 21 years of age (see OAR 461-120-0050), the state of residence is one of the following:

(a) The state of residence of the individual's parent or legal guardian at the time of application.

(b) The state of residence of the party who applies for benefits on the individual's behalf if there is no living parent or the location of the parent is unknown, and there is no legal guardian.

(c) Oregon, if the individual has been receiving medical assistance in Oregon continuously since November 1, 1981, or is from a state with which Oregon has an interstate agreement that waives the residency requirement.

(d) When a state agency of another state places the individual, the individual is considered to be a resident of the state that makes the placement.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706, 411.816, 412.006, 412.014, 412.049, 412.124, 414.231
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.706, 411.816, 412.006, 412.014, 412.049, 412.124, 414.231
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-120-0125
Alien Status

(1) For purposes of this chapter of rules, an individual is a "qualified non-citizen" if the individual is any of the following:

(a) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 1101 et seq).

(b) A refugee who is admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157).

(c) A non-citizen who is granted asylum under section 208 of the INA (8 U.S.C. 1158).

(d) A non-citizen whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1253(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 1231(b)(3)) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996)).

(e) A non-citizen who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year.

(f) A non-citizen who is granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980.

(g) A non-citizen who is a "Cuban and Haitian entrant" (as defined in section 501(3) of the Refugee Education Assistance Act of 1980).

(h) A battered spouse or dependent child who meets the requirements of 8 U.S.C. 1641(c), as determined by the U.S. Citizenship and Immigration Services.

(i) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).

(j) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).

(2) In all programs except the REF and REFM programs, an individual meets the alien status requirements if the individual is one of the following:

(a) An American Indian born in Canada to whom the provisions of section 289 of the INA (8 U.S.C. 1359) apply.

(b) A member of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e)).

(3) In the ERDC, TA-DVS, and TANF programs, an individual meets the alien status requirements if the individual is one of the following:

(a) An individual who is a qualified non-citizen (see section (1) of this rule).

(b) A non-citizen who is currently a victim of domestic violence or who is at risk of becoming a victim of domestic violence.

(c) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the INA.

(4) In the OSIPM and QMB programs an individual meets the alien status requirement if:

(a) The individual is a non-citizen who entered the United States or was given qualified non-citizen status on or after August 22, 1996 and has been in the U.S. for five years beginning on the date the non-citizen received his or her qualified non-citizen status; or

(b) The individual meets the requirements of one of the following subsections:

(A) An individual granted any of the following alien statuses:

(i) Refugee — under section 207 of the INA.

(ii) Asylum — under section 208 of the INA.

(iii) Deportation being withheld under section 243(h) of the INA.

(iv) Cubans and Haitians who are either public interest or humanitarian parolees.

(v) An individual granted immigration status under section 584(a) of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988.

(vi) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).

(vii) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).

(viii) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the INA.

(B) Effective October 1, 2009, an individual is a qualified non-citizen and is under 19 years of age.

(C) Was a qualified non-citizen before August 22, 1996.

(D) Physically entered the United States before August 22, 1996, and was continuously present in the United States between August 22, 1996, and the date qualified non-citizen status was obtained. An individual is not continuously present in the United States if the individual is absent from the United States for more than 30 consecutive days or a total of more than 90 days between August 22, 1996 and the date qualified non-citizen status was obtained.

(E) Is under the age of 19 and is one of the following:

(i) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.

(ii) An individual described in 8 CFR section 103.12(a)(4) who belongs to one of the following classes of aliens permitted to remain in the United States because the Attorney General has decided for humanitarian or other public policy reasons not to initiate deportation or exclusion proceedings or enforce departure:

(I) An alien currently in temporary resident status pursuant to section 210 or 245A of the INA (8 USC 1160 and 1255a);

(II) An alien currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 USC 1229b);

(III) Cuban-Haitian entrants, as defined in section 202(b) Pub. L. 99–603 (8 USC 1255a), as amended;

(IV) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101–649 (8 USC 1255a), as amended;

(V) An alien currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(VI) An alien currently in deferred action status pursuant to Department of Homeland Security Operating Instruction OI 242.1(a)(22); or

(VII) An alien who is the spouse or child of a United States citizen whose visa petition has been approved and who has a pending application for adjustment of status.

(iii) An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including those individuals as specified in section 101(a)(15) of the INA (8 USC 1101).

(F) In the OSIPM program, is receiving SSI benefits.

(G) In the QMB program, is receiving SSI and Medicare Part A benefits.

(H) Meets the alien status requirements in section (2) or (6) of this rule.

(5) In all programs except the ERDC, REF, REFM, and TANF programs, a qualified non-citizen meets the alien status requirement if the individual is:

(a) A veteran of the United States Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty service requirements described in 38 U.S.C. 5303A(d).

(b) A member of the United States Armed Forces on active duty (other than active duty for training).

(c) The spouse or a dependent child of an individual described in subsection (a) or (b) of this section.

(d) In the SNAP program, a qualified non-citizen who meets the requirement in section (10) of this rule.

(6) In the REF and REFM programs, an individual meets the alien status requirements if the individual is admitted lawfully under any of the following provisions of law:

(a) An individual admitted as a refugee under section 207 of the INA (8 USC 1157).

(b) An individual granted asylum under section 208 of the INA (8 USC 1158).

(c) Cuban and Haitian entrants, in accordance with requirements in 45 CFR part 401.

(d) An individual paroled as a refugee or asylee under section 212(d)(5) of the Immigration and Nationality Act (INA) (8 USC 1182(d)(5)). For purposes of this section, "Lautenberg" parolees, humanitarian interest parolees, and other public interest parolees do not qualify.

(e) An Amerasian from Vietnam who is admitted to the U.S. as an immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Pub. L. No. 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 (Pub. L. No. 100-461 as amended)).

(f) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. No. 106-386, 114 Stat. 1464 (2000), as amended.

(g) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003, Pub. L. 108-193, 117 Stat. 2875 (2003).

(h) Iraqi and Afghan aliens granted special immigrant status under section 101(a)(27) of the Immigration and Nationality Act.

(7) In the SNAP program, an individual meets the alien status requirement if the individual meets the requirements of one or more of the following subsections:

(a) An individual granted any of the following alien statuses;

(A) Refugee — under section 207 of the INA.

(B) Asylum — under section 208 of the INA.

(C) Deportation being withheld under section 243(h) of the INA.

(D) Cubans and Haitians who are either public interest or humanitarian parolees.

(E) An individual granted immigration status under section 584(a) of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988.

(F) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).

(G) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).

(H) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the INA.

(b) A qualified non-citizen under 18 years of age.

(c) A non-citizen who has been residing in the United States for at least five years while a qualified non-citizen.

(d) A non-citizen who is lawfully residing in the United States and who was a member of a Hmong or Highland Laotian tribe at the time that the tribe rendered assistance to United States personnel by taking part in a military or rescue operation during the Vietnam era (as defined in 38 U.S.C. 101).

(e) The spouse, the un-remarried surviving spouse, or an unmarried dependent child, of an individual described in subsection (d) of this section.

(f) A qualified non-citizen who has a disability, as defined in OAR 461-001-0015.

(8) A client who is lawfully admitted to the United States for permanent residence under the INA and has worked 40 qualifying quarters of coverage as defined under title II of the Social Security Act, or can be credited with such qualifying quarters as provided under 8 U.S.C. 1645, meets the alien status requirements for the SNAP program, subject to the following provisions:

(a) No quarter beginning after December 31, 1996, is a qualifying quarter if the client received any federal, means-tested benefit during the quarter. Federal means-tested benefits include SNAP, TANF, and Medicaid (except emergency medical).

(b) For the purpose of determining the number of qualifying quarters of coverage, a client is credited with all of the quarters of coverage worked by a parent of the client while the client was under the age of 18 and all of the qualifying quarters worked by a spouse of the client during their marriage, during the time the client remains married to such spouse or such spouse is deceased.

(c) A lawful permanent resident who would meet the alien status requirement, except for a determination by the Social Security Administration (SSA) that the individual has fewer than 40 quarters of coverage, may be provisionally certified for SNAP program benefits while SSA investigates the number of quarters creditable to the client. A client provisionally certified under this section who is found by SSA, in its final administrative decision after investigation, not to have 40 qualifying quarters is not eligible for SNAP program benefits received while provisionally certified. The provisional certification is effective according to the rule on effective dates for opening benefits, OAR 461-180-0080. The provisional certification cannot run more than six months from the date of original determination by SSA that the client does not have sufficient quarters.

Stat. Auth.: ORS 411.060, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 414.231

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 414.025, 414.231, 414.826

Hist.: AFS 17-1992, f. & cert. ef. 7-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 32-1996(Temp), f. & cert. ef. 9-23-96; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 22-1998, f. 10-30-98, cert. ef. 11-1-98; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 17-2001(Temp), f. 8-31-01, cert. ef. 9-1-01 thru 9-30-01; 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; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 29-2003(Temp), f. 10-31-03, cert. ef. 11-1-03 thru 3-31-04; SSP 36-2003(Temp), f. 12-31-03 cert. ef. 1-1-04 thru 3-31-04; SSP 6-2004, f. & cert. ef. 4-1-04; SSP 10-2004(Temp), f. & cert. ef. 4-9-04 thru 6-30-04; SSP 14-2004(Temp), f. & cert. ef. 5-11-04 thru 6-30-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 7-2005, f. & cert. ef. 7-1-05; 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 11-2006(Temp), f. 6-30-06, cert. ef. 7-1-06 thru 9-30-06; 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 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 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 9-2009(Temp), f. & cert. ef. 5-1-09 thru 10-28-09; SSP 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 28-2009, f. & cert. ef. 10-1-09; 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 18-2010, f. & cert. ef. 7-1-10; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 2-2016, f. & cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-120-0210

Requirement to Provide Social Security Number (SSN)

(1) In the CAWEM, ERDC, REF, and REFM programs, a member of a need group (see OAR 461-110-0630) or a benefit group (see OAR 461-110-0750) is not required to provide or apply for a social security number (SSN). In these programs, the Department may request that a member of the filing group (see OAR 461-110-0310) or need group provide an SSN on a voluntary basis.

(2) In the EA and TA-DVS programs, an individual must provide his or her SSN if the individual can.

(3) Except as provided in section (5) of this rule, in the OSIPM and QMB programs:

(a) An individual is not required to apply for or provide an SSN:

(A) If the individual does not have an SSN; and

(B) May only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104.

(b) When subsection (a) does not apply, to be included in the benefit group, an individual must:

(A) Provide a valid SSN for the individual; or

(B) Apply for a number if the individual does not have a valid one and provide the SSN when it is received.

(4) Except as provided in sections (6) to (8) of this rule, in the SNAP program, to be included in the need group, an individual (other than an unborn) must:

(a) Provide a valid SSN for the individual; or

(b) Apply for a number if the individual does not have one and provide the SSN when it is received.

(5) In the TANF program, to be included in the benefit group, an individual must:

(a) Provide a valid SSN for the individual; or

(b) Provide verification of application for a SSN if the individual does not have one and provide the SSN within six months of the individual's initial TANF approval or by the end of the certification period (see OAR 461-001-0000), whichever is sooner.

(6) In the OSIPM, QMB, and SNAP programs, an individual is not required to apply for or provide an SSN if the individual is:

(a) A member of a religious sect or division of a religious sect that has continuously existed since December 31, 1950; and

(b) Adheres to its tenets or teachings that prohibit applying for or using an SSN.

(7) The requirement to apply for or provide the SSN is delayed as follows:

(a) In the SNAP program:

(A) An applicant eligible for expedited services may receive his or her first full month's allotment without meeting the SSN requirement but must meet the requirement before receiving a second full month's allotment.

(B) Before applying for or providing an SSN, a newborn may be included in a benefit group (see OAR 461-110-0750) for six months following the date the child is born or until the group's next recertification, whichever is later.

(b) In the TANF program, a child born in an Oregon hospital may be added to the benefit group for six months following the child's date of birth or until the next redetermination of eligibility (see OAR 461-001-0000) of the filing group (see OAR 461-110-0310 and 461-110-0330), whichever is sooner.

(8) In the SNAP program:

(a) An individual who refuses or fails without good cause to provide or apply for an SSN when required by this rule is ineligible to participate. This period of ineligibility continues until the individual provides the SSN to the Department.

(b) An individual may participate in SNAP for one month in addition to the month of application, if the individual can show good cause why the application for an SSN has not been completed. To continue to participate, the individual must continue to show good cause each month until the application for an SSN is complete with Social Security Administration.

(c) An individual meets the good cause requirement in subsections (a) and (b) of this section if the individual provides evidence or collateral information that the individual applied for or made every effort to supply the Social Security Administration with the necessary information to complete the application process. Delays due to illness not associated with a disability (see OAR 461-001-0015), lack of transportation, or temporary absence do not qualify as good cause under this rule.

(9) This rule authorizes or requires the collection of an SSN for each of the following purposes.

(a) The determination of eligibility for benefits. The SSN is used to verify income and other assets, and match with other state and federal records such as the Internal Revenue Service (IRS), Medicaid, child support, Social Security benefits, and unemployment benefits.

(b) The preparation of aggregate information and reports requested by funding sources for the program providing benefits.

(c) The operation of the program applied for or providing benefits.

(d) Conducting quality assessment and improvement activities.

(e) Verifying the correct amount of payments, recovering overpaid benefits, and identifying any individual receiving benefits in more than one household.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 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, 414.025, 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 20-1992, 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 9-1999, f. & cert. ef. 7-1-99; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; 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 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 12-2013(Temp), f. & cert. ef. 5-29-13 thru 11-25-13; SSP 24-2013, f. & cert. ef. 10-1-13; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-120-0315
Medical Assignment

In the OSIPM, QMB, and REFM programs:

(1) By signing the application for assistance, a client agrees to turn over the rights of each member of the benefit group (see OAR 461-110-0750) to reimbursement for medical care costs to the Department.

(a) If a client or the client's authorized representative (see OAR 461-115-0090) refuses to assign the rights to reimbursement for medical care costs to the Department, the filing group is ineligible until the client complies with this requirement. This includes a client eligible for long term care (see OAR 461-001-0000) insurance payments who fails to comply as described in subsection (b) of this section.

(b) When a client has long term care insurance, the client complies with the requirements of this rule by reducing the Department's share of the long term care service costs by taking the following actions for the entire period of time that the client is eligible for Department-covered long term care services:

(A) For a client in a nursing facility:

(i) Submitting the necessary paperwork to receive the long term care insurance payments and designating the long term care facility as the payee for the long term care insurance benefits; or

(ii) When the insurance company will not pay the long term care insurance benefits directly to the long term care facility, submitting the necessary paperwork to receive insurance payments and then promptly turning over the long term care insurance payments to the long term care facility upon receipt.

(B) For a client in community based care (see OAR 461-001-0000):

(i) Submitting the necessary paperwork to receive the long term care insurance payments and designating the Department as the payee for the long term care insurance benefits; or

(ii) When the insurance company will not pay the long term care insurance benefits directly to the Department, submitting the necessary paperwork to receive the insurance payments and then promptly turning over the long term care insurance payments to the Department upon receipt.

(2) The Department may refuse to pay medical expenses for anyone in the benefit group when another party or resource should pay first.

(3) The amount the Department may collect in reimbursement is limited to the amount of medical services paid by the Department on the client's behalf.

(4) The Department establishes an overpayment if it is discovered after-the-fact that during any period of time a client or another individual submitting a long term care insurance claim on the client's behalf received a long term care insurance payment that was not turned over to the long term care facility or Department as required by subsection (1)(b) of this rule.

Stat. Auth.: ORS 411.060, 411.404, 411.706, 414.231
Stats. Implemented: ORS 411.060, 411.404, 411.706, 414.231
Hist.: AFS 28-1992, f. & cert. ef. 10-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; 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 17-2011, f. & cert. ef. 7-1-11; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; ; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-120-0345
Clients Required to Obtain Health Care Coverage and Cash Medical Support; GAM, OSIPM

This rule explains the obligation of clients to obtain health care coverage and cash medical support for members of the benefit group (see OAR 461-110-0750) in the OSIPM program.

(1) Unless excused from the requirements of this section for good cause defined in OAR 461-120-0350, each adult client must assist the Department and the Division of Child Support of the Department of Justice in establishing paternity for each of his or her children and obtaining an order directing the non-custodial parent (see OAR 461-001-0000) of a child (see OAR 461-001-0000) in the benefit group to provide:

(a) Cash medical support for that child; and

(b) Health care coverage for that child.

(2) Each adult client must make a good faith effort to obtain available coverage under Medicare.

(3) To be eligible for the OSIPM program, once informed of the requirement, an individual who is able to must apply for, accept, and maintain cost-effective, employer-sponsored health insurance (see OAR 461-155-0360). In the OSIPM program, the client is not required to incur a cost for the health insurance.

(4) An individual who fails to meet an applicable requirement in sections (1), (2), or (3) of this rule is removed from the need group (see OAR 461-110-0630).

(5) In the case of an individual failing to meet the requirements of section (1) of this rule, the Department applies the penalty after providing the client with notice and opportunity to show the provisions of OAR 461-120-0350 apply.

(6) The penalty provided by this rule ends when the client meets the requirements of this rule.

Stat. Auth: ORS 411.060, 411.070, 412.024, 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.070, 412.001, 412.024, 412.049, 414.025, 414.042
Hist.: AFS 28-1992, f. & cert. ef. 10-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 30-1996, f. & cert. ef. 9-23-96; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 29-2003(Temp), f. 10-31-03, cert. ef. 11-1-03 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 6-2004, f. & cert. ef. 4-1-04; 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 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 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-120-0350
Clients Excused for Good Cause from Compliance with Requirements to Pursue Child Support, Health Care Coverage, and Medical Support

(1) A client is excused from the requirements of OAR 461-120-0340(1) and 461-120-0345(1)(a) if:

(a) The client's compliance would result in emotional or physical harm to the dependent child (see OAR 461-001-0000) or to the caretaker relative (see OAR 461-001-0000). The statement of the caretaker relative alone is prima facie evidence that harm would result;

(b) The child was conceived as a result of incest or rape and efforts to obtain support would be detrimental to the dependent child. The statement of the caretaker relative alone is prima facie evidence on the issues of conception and detrimental effect to the dependent child;

(c) Legal proceedings are pending for adoption of the needy child; or

(d) The parent is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption.

(2) In the REFM program, a pregnant client is excused from the requirements of OAR 461-120-0345.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706, 411.816, 412.006, 412.014, 412.049, 412.124, 414.231
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.706, 411.816, 412.006, 412.014, 412.049, 412.124, 414.231
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 8-1992, f. & cert. ef. 4-1-92; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; 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 19-1997, f. & cert. ef. 10-1-97; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-120-0510
Age Requirements for Clients to Receive Benefits

(1) If the year of an individual's birth is known but the month is unknown, the month of birth is presumed to be July. If the date of birth is unknown, the date of birth is presumed to be the first of the month.

(2) To be eligible for the TANF program:

(a) A dependent child (see OAR 461-001-0000) must be:

(A) Under 18 years of age; or

(B) Under 19 years of age and regularly attending school (see subsection (c) of this section) full time, as determined by the school.

(b) A caretaker relative (see OAR 461-001-0000) may be any age.

(c) "Regularly attending school" means enrolled in and attending any of the following:

(A) A school in grade 12 or below, including home schooling approved by the local school district.

(B) GED classes in lieu of high school.

(C) A course of vocational or technical training, including Job Corps, in lieu of high school.

(D) The Oregon School for the Deaf.

(d) The student's full-time status is defined by the school.

(e) Regular attendance continues when a student misses school because of an illness, family emergency, or vacation, as long as the student intends to return to school. Students are considered to be in attendance for the full month in which they complete or discontinue school or training.

(3) To be eligible for payment of child care costs for the ERDC or TANF program, a child must be;

(a) Under 12 years of age for the ERDC program or under 13 years of age for the TANF program; or

(b) Under 18 years of age and;

(A) Physically or mentally incapable of selfcare;

(B) Under court supervision;

(C) Receiving foster care;

(D) Eligible for the special need rate for child care in OAR 461-155-0150; or

(E) Subject to circumstances that significantly compromise the child's safety or the caretaker's ability to work or participate in an assigned activity if child care is not available.

(4) To be eligible for the OSIP-AB, OSIPM-AB, QMB-BAS, QMB-SMB, REFM, or SNAP programs, a client may be any age.

(5) To be eligible for the OSIP-AD (except OSIP-EPD), OSIPM-AD (except OSIPM-EPD), and QMB-DW programs, a client must be under 65 years of age.

(6) To be eligible for the OSIP-EPD and OSIPM-EPD programs, the client must be 18 years of age or older or be legally emancipated.

(7) To be eligible for the OSIP-OAA or OSIPM-OAA programs, a client must be 65 years of age or older.

(8) To be eligible for the REF program, a client must be:

(a) 18 years of age or older;

(b) A legally emancipated minor; or

(c) Part of a TANF filing group (see OAR 461-110-0310) that is ineligible for the TANF program.

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 12-1990, f. 3-30-90, cert. ef. 4-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 20-1991, f. & cert. ef. 10-1-91; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; 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 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 5-1998(Temp), f. & cert. ef. 3-11-98 thru 5-31-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; 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 1-2000, f. 1-13-00, cert. ef. 2-1-00; AFS 18-2001(Temp), f. 8-31-01, cert. ef. 9-1-01 thru 12-31-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 10-2002, f. & cert. ef. 7-1-02; 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 17-2004, f. & cert. ef. 7-1-04; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; 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 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-125-0510

Impairment Criteria; GA, GAM

(1) To be eligible for GA and GAM, an individual must meet one of the following criteria:

(a) Have a physical or mental impairment that meets or equals the listing of impairments found in 20 CFR 404, Subpart P, Appendix 1, in effect November 1, 2003, and can be expected to:

(A) Last for a continuous period of not less than 12 months from the date of request; or

(B) Result in death within 12 months from the date of request.

(b) Be 55 years of age or older and meet the following requirements:

(A) Have a severe physical or mental impairment that does not meet the listing of impairments referred to in subsection (a) of this section but will:

(i) Prevent the individual from returning to any past relevant work for a period of not less than 12 months from the date of request; or

(ii) Result in death within 12 months from the date of request.

(B) Be limited to sedentary residual functioning capacity as defined in 20 CFR 404, subpart P, appendix 2, in effect November 1, 2003.

(c) Be 55 years of age or older and have all of the following:

(A) A severe physical or mental impairment that does not meet the listing of impairments referred to in subsection (a) of this section but will:

(i) Last for a period of not less than 12 months from the date of request; or

(ii) Result in death within 12 months from the date of request.

(B) Less than a 12th grade education, as evidenced by the lack of a high school diploma or GED.

(C) A history of no past relevant work as defined in section (2) of this rule in the last 15 years.

(d) Be age 50 or older but not yet age 55: and

(A) Have a severe physical or mental impairment that does not meet the listing of impairments referred to in subsection (a) of this section but will:

(i) Last for a period of not less than 12 months from the date of request; or

(ii) Result in death within 12 months from the date of request.

(B) Be illiterate or unable to communicate in English.

(C) Be limited to light residual functioning capacity as defined in 20 CFR 404, subpart P, appendix 2, in effect November 1, 2003.

(D) Have a past relevant work history of "unskilled" or "none."

(e) Be age 50 or older but not yet age 55: and

(A) Have a severe physical or mental impairment that does not meet the listing of impairments referred to in subsection (a) of this section but will:

(i) Last for a period of not less than 12 months from the date of request; or

(ii) Result in death within 12 months from the date of request.

(B) Have less than a High School education.

(C) Be limited to sedentary residual functioning capacity as defined in 20 CFR 404, subpart P, appendix 2, in effect November 1, 2003.

(D) Have a past relevant work history of "unskilled" or "none."

(f) Be age 45 or older but not yet age 50: and

(A) Have a severe physical or mental impairment that does not meet the listing of impairments referred to in subsection (a) of this section but will:

(i) Last for a period of not less than 12 months from the date of request; or

(ii) Result in death within 12 months from the date of request.

(B) Be illiterate or unable to communicate in English.

(C) Be limited to sedentary residual functioning capacity as defined in 20 CFR 404, subpart P, appendix 2, in effect November 1, 2003.

(D) Have a past relevant work history of unskilled or none.

(2) As used in this rule:

(a) "Basic work activity" means any kind of work activity that averages at least eight hours a day for which income is received, regardless of the adequacy to meet the client's needs. Work performed against medical advice or at an activity center or sheltered workshop is not basic work activity.

(b) "Equaling" means the medical findings are at least equal in severity and duration to the listed findings. If the client's impairment is not listed, the Department considers the listed impairment most like the client's impairment to decide whether the client's impairment is medically equal to the listed impairment. If the client has more than one impairment, and none of them meets or equals a listed impairment, the Department reviews the symptoms, signs, and laboratory findings about the client's impairments to determine whether the combination of those impairments is medically equal to a listed impairment.

(c) "Light work" means work that requires lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds and requires occasional stooping. It also requires standing or walking for a total of approximately six hours of an eight-hour workday.

(d) "Past relevant work" means work that the individual has performed in the last 15 years and that constitutes substantial gainful activity as defined in 20 CFR 404.1574 and 404.1575, in effect November 1, 2003. Also, the past relevant work must have lasted long enough for the individual to learn the techniques, acquire the necessary information, and develop the facilities needed for average performance of the job situation.

(e) "Sedentary work" means work that requires lifting no more than 10 pounds at a time and occasionally lifting or carrying articles such as docket files, ledgers, and small tools. Although sitting is involved, a certain amount of walking and standing is often necessary in carrying out job duties. Periods of walking and standing should total no more than two hours of an eight-hour workday and sitting should total approximately six hours of an eight-hour workday. Most unskilled sedentary jobs require good use of the hands and fingers for repetitive hand finger actions.

(f) "Severe mental impairment" means a mental impairment that significantly limits the individual's ability to do basic work activity.

(g) "Severe physical impairment" means a physical impairment that significantly limits the individual's physical ability to do basic work activity.

(h) "Unskilled work" is work that requires little or no judgment to do simple duties that can be learned on the job within 30 days.

(3) An applicant is not eligible for GA or GAM if drug addiction or alcoholism is material to his or her disability.

(4) If the client is unable to do so, the Department will obtain medical evidence that documents a claim of physical or mental impairment.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 411.060, 411.070, 411.710, 411.404
Stats. Implemented: ORS 411.060, 411.070, 411.710, 411.404
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 6-1994, f. & cert. ef. 4-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 40-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 21-1996, f. 5-30-96, cert. ef. 6-1-96; AFS 24-1996(Temp), f. & cert. ef. 6-11-96; AFS 34-1996, f. 9-26-96, cert. ef. 10-1-96; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 23-2000(Temp), f. 9-29-00, cert. ef. 10-1-00 thru 12-31-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 35-2000(Temp), f. 12-29-00, cert. ef. 1-1-01 thru 3-31-01; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 12-2001, f. 6-29-01, cert. ef. 7-1-01; AFS 4-2002(Temp), f. & cert. ef. 4-1-02 thru 6-30-02; AFS 10-2002, f. & cert. ef. 7-1-02; 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 15-2004(Temp), f. & cert. ef. 6-1-04 thru 9-30-04; SSP 22-2004, f. & cert. ef. 10-1-04; Suspended by SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-125-0810
Using Administrative Medical Examinations

(1) When the Department is responsible for making a decision of SFPSS disability determination, OSIP or OSIPM disability or OSIP or OSIPM blindness, or TANF incapacity, the client may select a qualified medical provider to complete the medical evaluation described in OAR 461-125-0830.

(2) A decision to deny or end benefits must be reconsidered when additional medical documentation relevant to the decision is received by the Department within 30 days of the original effective date of denial or termination.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706, 411.710, 412.014
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.706, 411.710, 412.014, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 7-1999, f. 4-27-99, cert. ef. 5-1-99; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; 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 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-135-0560
Fleeing Felon and Violators of Parole, Probation, and Post-Prison Supervision; GA, GAM, SNAP and TANF

(1) A person is ineligible for the SNAP and TANF programs if he or she is a fleeing felon or in violation of parole, probation, or post-prison supervision.

(2) A fleeing felon is a person who knowingly flees to avoid either of the following:

(a) Prosecution or custody for a crime or attempt to commit a crime that is classified as a felony.

(b) Confinement following conviction of a felony.

(3) For purposes of this rule, the crime must be considered a felony under the laws of the place from which the person is fleeing or, in the case of New Jersey, a high misdemeanor under the law of New Jersey.

(4) A person is in violation of parole, probation, or post-prison supervision if the Department receives a report of this violation from a local, state, or federal corrections agency or court responsible for supervision of the person. The violation continues until the Department receives a report from the corrections agency or court that the person is no longer in violation.

(5) If there is a pending arrest warrant for a person for a felony, a high misdemeanor under the law of New Jersey, or a violation of parole, probation, or post-prison supervision, the person is ineligible under this rule if the person is aware of the arrest warrant and has not provided the Department with evidence on request that the person made a substantial effort within his or her ability to resolve the warrant.

(6) A person is no longer considered a fleeing felon if the arrest warrant is no longer pending or the person provides the Department with evidence that the person made a substantial effort within his or her ability to resolve the warrant.

Stat. Auth.: ORS 411.060, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.816, 412.049
Hist.: SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-135-0700
Specific Requirements; GA

(1) For purposes of this rule, "homeless" means any of the following:

(a) The individual does not have a fixed or regular nighttime residence;

(b) The individual will lose his or her own residence within 90 days due to eviction or the inability to pay rent or mortgage; or

(c) The individual's primary residence is one of the following:

(A) A supervised shelter that provides temporary accommodations.

(B) A halfway house or residence for individuals who may become institutionalized.

(C) A temporary accommodation in another individual's or family's residence for 90 days or less.

(D) A place not designed to be or ordinarily used as a place for individuals to sleep, such as a hallway, bus station, or similar place.

(2) To be eligible for GA, an individual must meet all of the following requirements:

(a) The individual must be an adult (OAR 461-001-0015);

(b) The individual must be "homeless" (see section (1) of this rule);

(c) The individual must not be living with his or her child (see OAR 461-001-0000);

(d) The individual must not be receiving TANF benefits;

(e) The individual must be eligible for and receiving OSIPM with a basis of need established under OAR 461-125-0370(1)(c).

(f) The individual must be not be in a nonstandard living arrangement (see OAR 461-001-0000) other than at home receiving in-home services (see OAR 411-030-0020).

(g) The individual must complete the application process for Supplemental Security Income (SSI); cooperate with the Department in applying to the Social Security Administration for SSI; appeal all denials of SSI made below the Appeal's Council level; and attend all appointments designated by the Department relating to obtaining SSI.

(h) The individual must meet the non-financial, non-disability requirements for SSI.

(i) The individual must sign an interim assistance agreement authorizing the Department to recover interim GA benefits paid to the client (or paid to providers on the client's behalf) from the initial SSI payment or initial post-eligibility payment. The following provisions are considered part of the interim assistance agreement:

(A) Interim GA benefits include only those GA cash benefits paid during the period of time that the SSI benefit covers.

(B) For any month in which SSI is prorated, the Department can recover only a prorated amount of the interim GA cash benefit.

(C) If the Department cannot stop delivery of a GA benefit issued after the SSI payment is made, the GA payment will be included in the interim assistance to be reimbursed to the Department.

(3) Financial Eligibility.

(a) The OSIPM income and resource methodology are used to determine financial eligibility for the GA program.

(b) The GA benefit amount is determined according to OAR 461-160-0500 and 461-155-0210.

(4) If the Department determines that the individual no longer has an impairment that meets the criteria in OAR 461-125-0370, the individual is ineligible for GA.

(5) An individual found by the Social Security Administration (SSA) not to meet disability criteria at the initial, reconsideration, or hearing level may continue receiving GA benefits until all SSA administrative appeals are exhausted.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.710, OL 2016, ch 93
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 20-1991, f. & cert. ef. 10-1-91; 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 4-1997(Temp), f. 4-30-97, cert. ef. 5-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 5-2000, f. 2-29-00, cert. ef. 3-1-00; AFS 10-2002, f. & cert. ef. 7-1-02; 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 36-2003(Temp), f. 12-31-03 cert. ef. 1-1-04 thru 3-31-04; SSP 6-2004, f. & cert. ef. 4-1-04; SSP 11-2004(Temp), f. & cert. ef. 4-15-04 thru 6-30-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-135-0701
Terminate GA and GAM Programs October 1, 2005; Reinstate GA July 1, 2016

(1) Effective October 1, 2005, funding for the General Assistance (GA) and General Assistance Medical (GAM) programs was discontinued. These programs closed, effective October 1, 2005.

(2) Effective September 30, 2005, all persons eligible for or receiving benefits of the GA or GAM programs became ineligible for these programs. Except as provided in section (4) and (5) of this rule, the Department did not authorize or provide any benefit under the GA or GAM programs after September 30, 2005.

(3) Effective October 1, 2005, all GA recipients who received medical assistance through the OSIPM program continued to receive OHP Plus benefits through the OSIPM program until they became otherwise ineligible.

(4) Effective October 1, 2005, all recipients of medical assistance through the GAM program who became ineligible for GAM on September 30, 2005 because of the closure of the GAM program received OHP benefits as follows:

(a) Clients who had been determined to meet the eligibility requirements of the OSIPM program (see OAR 461-125-0370 and the OSIPM eligibility requirements in OAR 461 Division 135) received the OHP Plus benefits package (see OAR 410-120-1210(2)(a)).

(b) Clients may have also received the OHP Plus benefits package for the period that;

(A) The Department had not previously made a determination about whether the client met the disability requirements for OSIPM under OAR 461-125-0370 and the OSIPM eligibility requirements in OAR 461 Division 135; and

(B) A determination was still pending about whether the client met the disability requirements for OSIPM under OAR 461-125-0370 and the OSIPM eligibility requirements in OAR 461 Division 135.

(c) Clients who did not qualify for the OHP Plus benefits may have been eligible for the OHP-OPU program under the eligibility requirements set out in OAR 461 Division 135, and if eligible, received the OHP Standard benefits package (see OAR 410-120-1210(2)(b)).

(5) Effective July 1, 2016, the GA program was reinstated.

Stat. Auth.: ORS 409.050 & 411.060

Stats. Implemented: ORS 411.010, 411.060, 411.710, 411.730 & 411.740, OL 2016, ch 93

Hist.: AFS 21-2002(Temp), f. & cert. ef. 12-30-02 thru 6-27-03; SSP 12-2003, f. 5-29-03, cert. ef. 6-1-03; 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 10-2005(Temp), f. & cert. ef. 8-29-05 thru 2-25-06; SSP 12-2005(Temp), f. & cert. ef. 9-20-05 thru 2-25-06; SSP 18-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-135-0705

Specific Requirements; GA, GAM Ineligible

(1) The following are ineligible for GA and GAM:

(a) A resident of a public institution or private psychiatric hospital.

(b) A person held for a proceeding in connection with his or her commitment to a public institution or private psychiatric hospital.

(2) A GA client found by the Social Security Administration (SSA) not to meet SSI disability criteria may continue receiving GA while appealing the SSA finding until a decision is rendered by an Administrative Law Judge (ALJ) for the Social Security Administration's Office of Hearings and Appeals. A client who unsuccessfully appeals to the ALJ is no longer eligible for GA.

(3) A client whose impairment no longer meets the criteria in OAR 461-125-0510 is ineligible for benefits.

(4) The decision by the ALJ is binding on the Department unless the client has a new or significantly worsened impairment.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060 & 411.710

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 40-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; 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; Suspended by SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-135-0708

Criteria for Developing a Plan for Self-support; GA, GAM, OSIP, OSIPM and QMB

(1) A client and the Department may develop a plan for self support in the OSIP, OSIPM, and QMB programs for a client who:

(a) Meets the applicable disability or impairment criteria; and

(b) Is not eligible for SSI.

(2) A plan for self support allows a client to retain a portion of his or her nonexcluded assets for a specific period of time to meet a specific occupational goal. The plan may provide for specialized or advanced education or training for clients with a severe disability.

(3) To be approved, a plan for self support must meet all of the following criteria:

(a) The plan must be in writing and approved by the Department.

(b) The plan must identify a realistic occupational goal, considering the client's physical limitations and capabilities.

(c) The goal of the plan must be to provide the client with income necessary to meet his or her needs, not just for improving potential earning capability or increasing self sufficiency within the home.

(d) Resources designated to support the plan must be kept in a separate bank account with a specific savings or planned disbursement goal for using the resources. Previously commingled funds must be put in a separate bank account in order for them to be considered designated for the plan.

(e) The duration of the plan must be limited to the time necessary to complete the plan but cannot exceed thirty six months plus an additional 12 months if necessary for completion of education or training.

(4) A client must do all of the following to comply with a plan for self-support:

(a) Report any changes in circumstances that require a change to the current plan.

(b) Follow through with the plan without any break in excess of the longer of:

(A) Normal vacations from school or training.

(B) Three months, unless the reasons are beyond his or her control.

(5) If a client fails to comply with the requirements of section (4) of this rule, program eligibility is redetermined without the resource exclusions allowed by OAR 461-145-0405.

(6) The client and the Department may revise a plan for self-support or may agree to a new plan. To be new, the plan must not have any relationship to the old plan. When a plan is revised or a new plan established:

(a) Resources designated to support the old plan may become a part of the revised or new plan.

(b) If changes are made in the amount of resources to support the plan, eligibility and the payment amount for program benefits are redetermined.

(c) If the duration of the revised plan in addition to the months the old plan was in effect exceeds the time limits in subsection (3)(e) of this rule, approval is limited to the remainder of the maximum period only.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 10-2002, f. & cert. ef. 7-1-02; Renumbered from 461-140-0440, 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 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-135-0950

Eligibility for Inmates and Residents of State Hospitals

(1) This rule sets out additional restrictions on the eligibility of inmates and residents of state hospitals for programs covered by Chapter 461 of the Oregon Administrative Rules.

(2) Definition of an "inmate".

(a) An inmate is an individual living in a public institution who is:

(A) Confined involuntarily in a local, state or federal prison, jail, detention facility, or other penal facility, including an individual being held involuntarily in a detention center awaiting trial or an individual serving a sentence for a criminal offense;

(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;

(C) Residing involuntarily in a facility that is under governmental control; or

(D) Receiving care as an outpatient while residing involuntarily in a public institution.

(b) An individual is not considered an inmate when:

(A) The individual is released on parole, probation, or post-prison supervision;

(B) The individual is on home- or work-release, unless the individual is required to report to a public institution for an overnight stay;

(C) The individual is staying voluntarily in a detention center, jail, or county penal facility after his or her case has been adjudicated and while other living arrangements are being made for the individual; or

(D) The individual is in a public institution pending other arrangements as defined in 42 CFR 435.1010.

(3) A "public institution" is any of the following:

(a) A state hospital (see ORS 162.135).

(b) A local correctional facility (see ORS 169.005): a jail or prison for the reception and confinement of prisoners that is provided, maintained and operated by a county or city and holds individuals for more than 36 hours.

(c) A Department of Corrections institution (see ORS 421.005): a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility.

(d) A youth correction facility (see ORS 162.135):

(A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or

(B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth, or youth offenders pursuant to a judicial commitment or order.

(4) Definition of serious mental illness. An individual has a serious mental illness if the individual has been diagnosed by a psychiatrist, a licensed clinical psychologist or a certified non-medical examiner as having dementia, schizophrenia, bipolar disorder, major depression or other affective disorder or psychotic mental disorder other than a substance abuse disorder and other than a disorder that is both;

(a) Caused primarily by substance abuse; and

(b) Likely to no longer meet the applicable diagnosis if the substance abuse discontinues or declines.

(5) An individual who resides in a public institution, meets the definition of a serious mental illness (see section (4) of this rule), and applies for medical assistance between 90 and 120 days prior to the expected date of the person's release from the public institution may be found eligible for medical assistance. If the individual is determined to be eligible, the effective date of the individual's medical assistance is the date the individual is released from the institution.

(6) A client who becomes a resident of a state hospital has medical benefits suspended for up to twelve full calendar months if the client is at least 21 years of age and under 65 years of age. When a client with suspended medical benefits is no longer a resident of the state hospital, medical benefits are reinstated effective the first day the client is no longer a resident, if the client continues to meet eligibility for the medical program.

(7) An individual residing in a state psychiatric institution may be eligible for OSIPM benefits if the individual:

(a) Receives services on a certified ward;

(b) Meets level of care as certified by Acumentra; and

(c) Meets one of the following:

(A) Is 65 years of age or older;

(B) Is under 21 years of age; or

(C) Is 21 years of age or older, if the basis of need is disability or blindness; eligibility was determined before the individual reached 21 years of age; and the individual entered the state hospital before reaching 21 years of age.

(8) For all programs covered under chapter 461 of the Oregon Administrative Rules:

(a) If a pregnant woman receiving medical assistance through the OSIPM program becomes an inmate of a public institution, her medical benefits are suspended. When the Department is informed the woman is no longer an inmate, her medical benefits are reinstated — effective on the first day she is no longer an inmate — if she is still in her protected period of eligibility under OAR 461-135-0010.

(b) If an individual receiving medical assistance through the OSIPM or QMB program becomes an inmate of a correctional facility with an expected stay of no more than 12 months, medical benefits are suspended for up to 12 full calendar months during the incarceration period. When the Department is notified that an individual with suspended benefits has been released, and the notification takes place within 10 days of the release, medical benefits are reinstated effective the first day the client is no longer an inmate if the client continues to meet eligibility for the medical program.

(9) In the GA and SNAP programs, in addition to the other provisions of this rule, an inmate released from a public institution on home arrest, and required to wear an electronic device to monitor his or her activity, is ineligible for benefits if the correctional agency provides room and board to the individual.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.816, 412.014, 412.049

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.439, 411.443, 411.445, 411.816, 412.014, 412.049, 414.426, 2011 OL 207

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 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 5-2000, f. 2-29-00, cert. ef. 3-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 21-2001(Temp), f. & cert. ef. 10-1-01 thru 12-31-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; SSP 17-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-30-06; 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 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 9-2014, f. & cert. ef. 4-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-135-0990

Specific Requirements; Reimbursement of Cost-Effective, Employer-Sponsored Health Insurance Premiums

(1) Clients or an eligible applicant (see section (2) of this rule) for a client in the OSIPM program may be reimbursed for their share of the premiums for private or employer-sponsored group health insurance if:

(a) The insurance covers a member of the benefit group (see OAR 461-110-0750);

(b) The insurance coverage is a comprehensive major medical plan that includes inpatient and outpatient hospital, physician, lab, x-ray and full prescription coverage; and

(c) The premium is cost-effective (see OAR 461-155-0360 and OAR 410-120-1960).

(2) An "eligible applicant" may be a non-Medicaid individual living in or outside of the household. The Department may pay a portion of or the entire premium if payment of the premium for the non-Medicaid individual is necessary in order to enroll the Department client in the group health plan (see OAR 410-120-1960).

Stat. Auth.: ORS 411.060, 411.070, 414.042

Stats. Implemented: ORS 411.060, 411.070, 414.042

Hist.: AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 2-1994, f. & cert. ef. 2-1-94; 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 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 23-2008, f. & cert. ef. 10-1-08; 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 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-140-0010

Assets; Income and Resources

(1) An available asset, either income or a resource, is categorized as either excluded or countable (defined in OAR 461-001-0000).

(2) The availability of resources is covered in OAR 461-140-0020.

(3) The availability of income is covered in OAR 461-140-0040.

(4) Excluded assets are identified in the rules in this chapter (see divisions 140 and 145 in particular) and are not considered when a client's eligibility and benefit level are determined.

(5) In the OSIP, OSIPM, and QMB programs, an asset excluded pursuant to a rule in OAR Chapter 461 remains excluded as long as the asset is used in a manner consistent with the rule that provided the exclusion.

(6) An available asset not specifically excluded is countable, and its value is used in determining the eligibility and benefit level of a client.

(7) An asset may not be counted as a resource and as income in the same month.

Stat. Auth: ORS 411.060, 411.070, 411.816, 412.049

Stats. Implemented: ORS 411.060, 411.070, 411.816, 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-140-0040

Determining Availability of Income

(1) This rule describes the date income is considered available, what amount of income is considered available, and situations in which income is considered unavailable.

(2) Income is considered available the date it is received or the date a member of the financial group (see OAR 461-110-0530) has a legal right to the payment and the legal ability to make it available, whichever is earlier, except as follows:

(a) Income usually paid monthly or on some other regular payment schedule is considered available on the regular payment date if the date of payment is changed because of a holiday or weekend.

(b) Income withheld or diverted at the request of an individual is considered available on the date the income would have been paid without the withholding or diversion.

(c) An advance or draw of earned income is considered available on the date it is received.

(d) Income that is averaged, annualized, converted, or prorated is considered available throughout the period for which the calculation applies.

(e) A payment due to a member of the financial group, but paid to a third party for a household expense, is considered available when the third party receives the payment.

(f) In prospective budgeting, income is considered available in the month the income is expected to be received (see OAR 461-150-0020).

(g) In the OSIP, OSIPM, and QMB programs, except for self-employment (see OAR 461-145-0915), wages that are earned in one period of time but paid in another are considered available when they are received, such as a teacher who works for nine months but is paid over twelve.

(3) The following income is considered available even if not received:

(a) Deemed income.

(b) In the ERDC, REF, REFM, and TANF programs, the portion of a payment from an assistance program, such as public assistance, unemployment compensation, or Social Security, withheld to repay an overpayment.

(c) In the OSIPM and QMB programs, the portion of a payment from an assistance program (such as public assistance, unemployment compensation, or Social Security) withheld to repay an overpayment of the same source:

(A) If withheld prior to July 1, 2014.

(B) If withheld on or after July 1, 2014 and:

(i) No member of the financial group was receiving OSIP, OSIPM, or QMB during the period the benefit was overpaid; or

(ii) The withheld amount is not excluded under paragraph (5)(e)(A) of this rule.

(d) In the SNAP program, the portion of a payment from the TANF program counted as disqualifying income under OAR 461-145-0105.

(4) The amount of income considered available is the gross before deductions, such as garnishments, taxes, or other payroll deductions including flexible spending accounts.

(5) The following income is not considered available:

(a) Wages withheld by an employer in violation of the law.

(b) Income received by another individual who does not pay the client his or her share.

(c) Income received by a member of the financial group after the individual has left the household.

(d) Moneys withheld from or returned to the source of the income to repay an overpayment from that source unless the repayment is countable (see OAR 461-001-0000):

(A) In the SNAP program, under OAR 461-145-0105.

(B) In the ERDC, REF, REFM, and TANF programs, under subsection (3)(b) of this rule.

(e) In the OSIP, OSIPM, and QMB programs:

(A) The portion of a payment from an assistance program, such as public assistance, unemployment compensation, or Social Security withheld on or after July 1, 2014 to repay an overpayment from the same source if at least one member of the financial group was receiving OSIP, OSIPM, or QMB during the period the benefit was overpaid. The amount considered unavailable cannot exceed the amount of the overpaid benefit previously counted in determining eligibility (see OAR 461-001-0000) for OSIP, OSIPM, or QMB.

(B) Monies withheld from or returned to a source of income, when the source is not an assistance program, to repay an overpayment of the same source.

(f) For an individual who is not self-employed, income required to be expended on an ongoing, monthly basis on an expense necessary to produce the income, such as supplies or rental of work space.

(g) Income received by the financial group but intended and used for the care of an individual not in the financial group as follows:

(A) If the income is intended both for an individual in the financial group and an individual not in the financial group, the portion of the income intended for the care of the individual not in the financial group is considered unavailable.

(B) If the portion intended for the care of the individual not in the financial group cannot readily be identified, the income is prorated evenly among the individuals for whom the income is intended. The prorated share intended for the care of the individual not in the financial group is then considered unavailable.

(h) In the ERDC, REF, REFM, SNAP, and TANF programs, income controlled by the client's abuser if the client is a victim of domestic violence (see OAR 461-001-0000), the client's abuser controls the income and will not make the money available to the filing group (see OAR 461-110-0310), and the abuser is not in the client's filing group.

(i) In the OSIP, OSIPM, and QMB programs, unearned income not received because a payment was reduced to cover expenses incurred by a member of the financial group to secure the payment. For example, if a retroactive check is received from a benefit program other than SSI, legal fees connected with the claim are subtracted. Or, if payment is received for damages received as a result of an accident the amount of legal, medical, or other expenses incurred by a member of the financial group to secure the payment are subtracted.

(j) In the REFM program, any income used for medical or medical-related purposes.

(6) The availability of lump-sum income (see OAR 461-001-0000) is covered in OAR 461-140-0120.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.117, 411.404, 411.706, 411.816, 412.049, 413.085, 414.685, 414.839

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 9-1991, f. 3-29-91, cert. ef. 4-1-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 17-1992, f. & cert. ef. 7-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; 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 13-2002, f. & cert. ef. 10-1-02; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 1-2005(Temp), f. & cert. ef. 2-1-05 thru 6-30-05; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 5-2005(Temp), f. & cert. ef. 4-1-05 thru 6-30-05; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 23-2014(Temp), f. & cert. ef. 9-19-14 thru 3-18-15; SSP 13-2015, f. & cert. ef. 3-19-15; SSP 25-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-140-0120

Availability and Treatment of Lump-Sum Income

(1) Lump-sum income (see OAR 461-001-0000) is treated as follows if it is received by a member of a financial group (see OAR 461-110-0530).

(2) In the EA, REF, REFM, SNAP, and TANF programs:

(a) Lump-sum income is a resource.

(b) In the EA, REF, REFM, and TANF programs:

(A) Lump-sum income is considered available to the financial group when a member of the group receives the income and until the income becomes unavailable for a reason beyond the group's control.

(B) Lump-sum income is considered unavailable for a reason beyond the group's control if the member who received the lump-sum income:

(i) Leaves the financial group before spending any of the lump-sum income; or

(ii) Spends the lump-sum income on an immediate basic need or emergency.

(3) In the ERDC program, lump-sum income is excluded.

(4) In the OSIP (except OSIP-EPD), OSIPM (except OSIPM-EPD), and QMB-DW programs, lump-sum income is treated as follows:

(a) Lump-sum income not excluded is unearned income in the month of receipt, and any amount remaining in future months is a resource, except that in the OSIP and OSIPM programs retroactive SSB and SSI payments are treated in accordance with OAR 461-145-0490 and 461-145-0510.

(b) The following lump-sum income is excluded:

(A) The first $20 received in a month;

(B) The income the client turns over to the Department as reimbursement for previous assistance; and

(C) The income the client uses to pay for special need items approved by the Department. Special needs are explained in OAR 461-155-0500 and following.

(5) In the OSIP-EPD and OSIPM-EPD programs, lump-sum income is counted as a resource.

(6) In the QMB-BAS, QMB-SMB, and QMB-SMF programs:

(a) Lump-sum income not excluded is unearned income in the month of receipt, except that retroactive SSB and SSI payments are treated in accordance with OAR 461-145-0490 and 461-145-0510.

(b) The following lump-sum income is excluded:

(A) The first $20 received in a month;

(B) The income the client turns over to the Department as reimbursement for previous assistance; and

(C) The income the client uses to pay for special need items approved by the Department. Special needs are explained in OAR 461-155-0500 and following.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 410.010, 410.020, 410.070, 410.080, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685, 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 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 1-1991(Temp), f. & cert. ef. 1-2-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 5-1993, f. & cert. ef. 4-1-93; 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 13-1994, f. & cert. ef. 7-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; 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 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 7-1999, f. 4-27-99, cert. ef. 5-1-99; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; 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 17-2004, f. & cert. ef. 7-1-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 4-2005, f. & cert. ef. 4-1-05; 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 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-140-0210
Asset Transfer; General Information and Timelines

(1) OAR 461-140-0210 to 461-140-0300 regulate the effect of a transfer of an asset on a client.

(2) If an asset is transferred during the periods of time listed in section (4) or (5) of this rule and if the transfer is made in whole or in part for the purpose of establishing or maintaining eligibility for benefits:

(a) In the REFM program, the filing group is disqualified if:

(A) A member of the financial group (see OAR 461-110-0530) transferred the asset; and

(B) The client is an inpatient in a nursing facility, or is an inpatient in a medical institution in which payment for the client is based on a level of care provided in a nursing facility.

(b) In the REF, SNAP, and TANF programs, the filing group is disqualified if:

(A) The asset was a resource; and

(B) A member of the financial group transferred the resource.

(c) In the OSIP and OSIPM programs, a client in a nonstandard living arrangement (see OAR 461-001-0000) is disqualified if the client or the spouse of the client transferred the asset.

(3) In all programs except the ERDC program, clients in financial groups whose members transfer an asset covered under section (2) of this rule within the time periods listed in section (4) or (5) of this rule must report the transfer as soon as practicable and must provide information requested by the Department concerning the transfer.

(4) In the REF, REFM, SNAP, and TANF programs, a transfer of an asset may be disqualifying if the transfer occurs:

(a) In the REFM program, during the three years preceding the date of request (see OAR 461-115-0030).

(b) In the SNAP program, during the three months preceding the filing date or during a certification period (see OAR 461-001-0000) if the asset was a resource.

(c) In the REF and TANF programs, during the three years preceding the date of request (see OAR 461-115-0030) if the asset was a resource.

(5) In the OSIP and OSIPM programs, for a client in a nonstandard living arrangement, a transfer of an asset may be disqualifying if the transfer occurs:

(a) On or before June 30, 2006 and as described in one of the following paragraphs:

(A) On or after the date that is 60 months prior to the date of request — for assets that are transferred without compensation equal to or greater than fair market value from a revocable trust (see OAR 461-145-0540(8)(c)).

(B) On or after the date that is 60 months prior to the date of request — for assets that are transferred without compensation equal to or greater than fair market value to an irrevocable trust (see OAR 461-145-0540(9)(a)).

(C) On or after the date that is 60 months prior to the date of request — when there is a change in circumstances that makes assets in an irrevocable trust unavailable to the client (see OAR 461-145-0540(9)(d)).

(D) On or after the date that is 36 months prior to the date of request — for assets transferred without compensation equal to or greater than fair market value from an irrevocable trust (see OAR 461-145-0540(9)(b) and (c)).

(E) On or after the date that is 36 months prior to the date of request — for other asset transfers made without compensation equal to or greater than fair market value.

(b) On or after;

(A) July 1, 2006; and

(B) The date that is 60 months prior to the date of request.

(6) The duration of the period of disqualification or ineligibility is set out in OAR 461-140-0260 to 461-140-0300.

Stat. Auth.: ORS 411.060, 411.404, 411.710, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.404, 411.710, 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 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 18-1993(Temp), f. & cert. ef. 10-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 27-2013, f. & cert. ef. 10-1-13; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-140-0242
Disqualifying Transfer of Assets Including Home; OSIP and OSIPM

For a client in a nonstandard living arrangement (see OAR 461-001-0000) in the OSIP and OSIPM programs:

(1) For the purposes of this rule:

(a) The definition of "child" in OAR 461-001-0000 does not apply.

(b) "Child" means a natural or adoptive son or daughter who is:

(A) Under age 21; or

(B) Any age and has been determined to meet the blindness criteria of OAR 461-125-0330 or the disability criteria of OAR 461-125-0370.

(2) A transfer of an asset (including a home) by a client or the spouse of the client is a disqualifying transfer unless the requirements of at least one of the following subsections are met:

(a) The transfer was made exclusively for purposes other than establishing eligibility or maintaining benefits.

(b) The title to the asset was transferred to the person's spouse, the person's child who is blind or has a disability under the criteria of the Social Security Administration, or another for the sole benefit of the spouse or a child who is blind or has a disability under the criteria of the Social Security Administration, provided that the transfer is arranged in such a way that no individual or entity except this spouse or child can benefit from the asset transferred in any way, whether at the time of transfer or any time in the future. A direct transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse or child who is blind or has a disability under the criteria of the Social Security Administration is not considered to be established for the benefit of one of those individuals. In order for a transfer or a trust to be considered for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual based on the life expectancy of the individual.

(c) The transfer was made to a trust described in OAR 461-145-0540(10), except that a transfer to a trust under OAR 461-145-0540(10)(a) is disqualifying if the client is age 65 or older.

(d) The transfer was made to a trust described in OAR 461-145-0540(11) established solely for the benefit of an individual under 65 years of age who has a disability that meets the criteria of the Social Security Administration. This subsection applies to all transfers made on or after July 1, 2006.

(e) The transfer is a transfer described in OAR 461-160-0580(2).

(f) The resource is transferred by the community spouse after the Department has determined the community spouse's resource allowance in accordance with OAR 461-160-0580 and the resource has not been attributed to the institutionalized spouse. Notwithstanding this subsection, a transfer of a resource by a community spouse who is receiving or applying for benefits remains subject to all rules regarding the transfer of an asset by a client.

(3) A transfer of a home by a client or the spouse of the client is a disqualifying transfer unless the title was transferred to the client's;

(a) Child;

(b) Sibling who has equity interest in the home and was residing in the home for at least one year immediately before the client's admission to long-term care (see OAR 461-001-0000); or

(c) Natural or adoptive son or daughter who meets the requirements of each of the following paragraphs:

(A) The son or daughter resided with the client in the client's home continuously for at least two years immediately prior to the client's admission to long-term care other than an absence from the home that is not intended to, and does not, exceed 30 days.

(B) The son or daughter provides convincing evidence that he or she provided services that permitted the client to reside at home for at least two years rather than in an institution or long-term care facility.

(C) Without receiving payment from the Department, the son or daughter must have directly provided the services required by paragraph (B) of this subsection as described in both of the following subparagraphs for a total of at least 20 hours per week.

(i) On a daily basis, one or a combination of any of the following activities of daily living, as each sub-subparagraph is further defined at OAR 411-015-0006:

(I) Eating.

(II) Dressing/Grooming.

(III) Bathing/Personal Hygiene.

(IV) Mobility.

(V) Elimination.

(VI) Cognition/Behavior.

(ii) One or a combination of any of the following instrumental activities of daily living, as each sub-subparagraph is further defined at OAR 411-015-0007:

(I) Housekeeping.

(II) Laundry.

(III) Meal Preparation.

(IV) Medication Management.

(V) Shopping.

(VI) Transportation.

(4) Except for a transfer permitted under section (3) of this rule, each of the following subsections applies in determining whether an asset is considered transferred for fair market value:

(a) The compensation received for the asset must be in a tangible form with intrinsic value.

(b) The Department presumes that services provided for free at the time were intended to be provided without compensation, and that a transfer to an individual for services provided for free in the past is a disqualifying transfer of assets. This presumption is rebuttable with convincing evidence. This evidence must also show that there was an express agreement to provide services for compensation at the time the services were provided.

(c) Compensation for services is valued at the average market rate at the time the services were provided, unless the express agreement provides a lower rate.

(5) If a transfer is made for less than fair market value and is not exempt from disqualification under this rule, there is a rebuttable presumption that the asset was transferred for the purpose of establishing or maintaining eligibility and is not exempt under subsection (2)(a) of this rule.

(6) To rebut the presumption in section (5) of this rule, the client must present evidence other than his or her own statement and must provide to the Department the information it requests for the purpose of evaluating the purpose of the transfer. To meet the burden, it is sufficient for the client to show one of the following:

(a) The decision to make the transfer was not within the client's control;

(b) At the time of transfer, the client could not reasonably have anticipated applying for medical assistance;

(c) Unexpected loss of resources or income occurred between the time of transfer and the application for medical assistance;

(d) Because of other, similarly convincing, circumstances, it appears more likely than not that the transfer was not made, in whole or in part, for the purpose of establishing or maintaining eligibility for benefits.

(7) The fact that a recipient was already eligible for benefits is not sufficient to rebut the presumption in section (5) of this rule because the asset may not always be excluded and if the client had received full compensation for the asset, the compensation received would have been used to determine future eligibility.

Stat. Auth.: ORS 411.060 & 411.710

Stats. Implemented: ORS 411.060, 411.710, 414.042

Hist.: 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 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; 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 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-140-0250

Determining The Uncompensated Value of a Transferred Asset

(1) The uncompensated value of a disqualifying transfer of an asset is used in OAR 461 140 0260 to 461-140-0300 to calculate the ineligibility period of the financial group (see OAR 461-110-0530).

(2) To determine uncompensated value:

(a) In the OSIP and OSIPM programs:

(A) The value of the compensation received for the asset is subtracted from the fair market value (see OAR 461-001-0000) of the asset. This result is the uncompensated value, unless the financial group had countable (see OAR 461-001-0000) resources of less than the resource limit at the time of the first transfer. If the financial group had countable resources of less than the resource limit at the time of the first transfer, the remainder is then added to other countable resources, and the amount by which the sum exceeds the resource limit in OAR 461-160-0015 is the uncompensated value.

(B) For an annuity, unless the client verifies a lesser amount, the fair market value is equal to the amount of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any earnings, minus any regular monthly payments already received, minus early withdrawals, and minus any surrender fees.

(b) In all other programs, the value of the compensation received for the resource is subtracted from the fair market value of the resource. The remainder is added to the other countable resources at the time of the transfer. The amount by which the sum exceeds the resource limit is the uncompensated value.

(c) The compensation received for a transferred asset includes:

(A) Encumbrances assumed by the buyer; and

(B) Goods or services provided to the client, limited to their true value, if there was a prior agreement to exchange the asset for the goods or services.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 410.020, 411.060, 411.070, 411.404, 411.632, 411.706, 411.816, 412.049, 413.085, 414.685, 414.839

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 11-2006(Temp), f. 6-30-06, cert. ef. 7-1-06 thru 9-30-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-140-0296

Length of Disqualification Due to an Asset Transfer; OSIP and OSIPM

(1) This rule applies to clients in the OSIP and OSIPM programs who live in a nonstandard living arrangement (see OAR 461-001-0000).

(2) A financial group (see OAR 461-110-0530) 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(10)(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; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-140-0300
Adjustments to the Disqualification for Asset Transfer

(1) The disqualification imposed under OAR 461-140-0260 is not adjusted once applied in the SNAP program.

(2) In all other programs, the disqualification ends if the transfer that caused the disqualification is rescinded. The duration of the disqualification is recalculated if the terms of the transfer are modified.

(3) In the OSIP, OSIPM, and REFM programs, the Department may waive the disqualification if the disqualification would create an undue hardship on the client. For purposes of this section, the disqualification would create an undue hardship if the requirements of subsections (a) and (b) of this section are met:

(a) The client has no other means for meeting his or her needs. The client has the burden of proving that no other means exist by;

(A) Exploring and pursuing all reasonable means to recover the assets to the satisfaction of the Department, including legal remedies and consultation with an attorney; and

(B) Cooperating with the Department to take action to recover the assets.

(b) The disqualification would deprive the client of;

(A) Medical care such that the client's health or life would be endangered; or

(B) Food, clothing, shelter, or other necessities of life without which the health or life of the client would be endangered.

(4) As authorized by ORS 411.620, the Department retains the authority to bring a civil suit or action to set aside a transfer of assets for less than fair market value and may seek recovery of all costs associated with such an action.

(5) Notwithstanding the granting of an undue hardship waiver under section (3) of this rule, the Department is not precluded from recovering public assistance or medical assistance from any assets in which the client held an interest, or in which the client previously held an interest, at the time the undue hardship waiver was granted.

Stat. Auth: ORS 409.050, 411.060, 411.404, 411.816, 412.014, 412.049
Stats. Implemented: ORS 409.010, 411.060, 411.404, 411.632, 411.816, 412.014, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 26-2000, f. & cert. ef. 10-4-00; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 27-2013, f. & cert. ef. 10-1-13; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0005
Agent Orange Disability Benefits

For all programs:

(1) Benefits from the Agent Orange Settlement Fund made by Aetna Life and Casualty for settling Agent Orange disability claims are excluded.

(2) Payments made under the Agent Orange Act of 1991, and issued by the U.S. Treasury through the Department of Veterans Affairs, are counted as unearned income.

Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.404, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.404, 411.816, 412.049
Hist.: AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0040
Burial Arrangements and Burial Fund

(1) The following definitions apply to this rule:

(a) "Burial arrangement" means an agreement with an entity — such as a funeral agreement (which means an arrangement made with a licensed funeral provider), burial insurance, or a burial trust designating a funeral director as the beneficiary — that makes allowance for burial costs. A "burial arrangement" does not include a burial space, which is covered in OAR 461-145-0050, or a burial fund (see subsection (b) of this section).

(b) "Burial fund" means an identifiable fund set aside for a client's burial costs. A "burial fund" does not include a burial space, which is covered in OAR 461-145-0050, or a burial arrangement (see subsection (a) of this section).

(2) Except as provided in subsection (e) of this section, a burial arrangement is treated as follows:

(a) In the ERDC, REF, REFM, SNAP, and TANF programs, the equity value (see OAR 461-001-0000) of one prepaid burial arrangement for each member of the filing group (see OAR 461-110-0310) is excluded.

(b) For grandfathered OSIP and OSIPM clients (see OAR 461-125-0330(2), 461-125-0370(1)(b), and 461-135-0771), up to $1,000 in combined equity value of each burial arrangement with a licensed funeral director (plus accrued interest) and life insurance policies are excluded. The amount of combined cash and equity value of all life insurance and burial arrangements that is over $1,000 is counted as a resource.

(c) In the OSIP, OSIPM, and QMB-DW programs, the amount in an irrevocable burial trust or any other irrevocable arrangement to cover burial costs is excluded.

(d) In all programs not listed in subsection (a) of this section and for OSIP and OSIPM clients not covered by subsection (b) of this section, a

burial arrangement is treated in the manner as the program treats a burial fund under section (3) of this rule.

(e) Burial insurance that has cash surrender value is considered life insurance and is treated in accordance with OAR 461-145-0320 and, as applicable, subsection (b) of this section.

(3) A burial fund is treated as follows:

(a) In the OSIP, OSIPM, and QMB-DW programs:

(A) A burial fund may be established only from financial means such as cash, burial contracts, bank accounts, stocks, bonds, or life insurance policies.

(B) A burial fund is counted as a resource if it is commingled with assets unrelated to a burial. The amount set aside for burial must be in a separate account to be excluded from resource consideration.

(C) A burial fund may be established if the countable (see OAR 461-001-0000) resources of a client exceed allowable limits. A burial fund is excluded from the resource calculation to the extent allowed in paragraph (D) of this subsection.

(D) The following calculation determines the exclusion for a burial fund:

(i) Up to $1,500 of a burial fund may be excluded from resources for each of the following:

(I) The client.

(II) The client's spouse.

(ii) The amount in subparagraph (i) of this paragraph is reduced by the total of the following amounts:

(I) The face value of life insurance policies owned by the client that have already been excluded from resources.

(II) The amount in an irrevocable burial trust or any other irrevocable arrangement to cover burial costs.

(E) All interest earned on an excluded burial fund or increases in the value of an excluded burial arrangement if left in the fund is excluded from income.

(b) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, a burial fund is excluded as a resource.

(c) In all programs not listed in subsections (a) or (b) of this section, a burial fund is counted as a resource.

(4) There is no overpayment for the time period during which the burial arrangement or burial fund existed if a client;

(a) Cancels an excluded burial arrangement; or

(b) Uses an excluded burial fund for any purpose other than burial costs.

(5) If an asset originally used as a burial arrangement or burial fund is converted to other uses, the asset is treated under the other applicable rules.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.049, 413.085, 414.685, 414.839

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 28-1992, f. & cert. ef. 10-1-92; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; 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 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0050

Burial Space and Merchandise

(1) Burial spaces include conventional grave sites, crypts, mausoleums, urns, and other repositories that are traditionally used for the remains of deceased individuals. Burial spaces also include headstones and the opening and closing of the grave.

(a) In the ERDC, REF, REFM, SNAP, and TANF programs, the equity value (see OAR 461-001-0000) of one burial space is excluded as a resource for each member of the financial group (see OAR 461-110-0530).

(b) In the OSIP, OSIPM, and QMB-DW programs, the equity value of a burial space is excluded as a resource if owned by the client and designated for the client, the spouse (see OAR 461-001-0000) of the client, minor and adult children, siblings, parents, and the spouse of any of these individuals.

(2) Burial merchandise includes, but is not limited to, caskets, liners, burial vaults, markers, and foundations. The equity value of burial merchandise is excluded as a resource if owned by the client and designated for:

(a) In the ERDC, REF, REFM, SNAP, and TANF programs, a member of the financial group.

(b) In the OSIP, OSIPM, and QMB-DW programs, the client, the spouse of the client, minor and adult children, siblings, parents, and the spouse of any of these individuals.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 410.020, 410.070, 410.080, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685, 414.839

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 13-1991, f. & cert. ef. 7-1-91; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; 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 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0110

Domestic Volunteer Services Act (VISTA, RSVP, SCORE, ACE)

In all Department programs covered by Chapter 461 of the Oregon Administrative Rules, with respect to federal programs under the Domestic Volunteers Service Act of 1973 (Pub. L. No. 93 113):

(1) Payments under Title I — VISTA, University Year of Action, and Urban Crime Prevention — are treated as follows:

(a) In the ERDC, REF, REFM, and TANF programs, these payments are excluded, except that these payments are counted as earned income if the total value of all compensation is equal to or greater than compensation at the state minimum wage.

(b) In all programs except the ERDC, REF, REFM, and TANF programs:

(A) The payments are excluded if the client is receiving Department program benefits when they join the Title I program. The exclusion of payments continues until the client has a break in receiving Department benefits of more than one month.

(B) The payments are counted as earned income for clients who joined the Title I program before applying for Department program benefits.

(2) Payments are excluded for programs under Title II (National Older Americans Volunteer Programs), which include:

(a) Retired Senior Volunteer Program (RSVP) Title II, Section 201.

(b) Foster Grandparent Program Title II, Section 211.

(c) Older American Community programs.

(d) Senior Companion Program.

(3) Payments are excluded for programs under Title III (National Volunteer Programs to Assist Small Businesses and Promote Volunteer Service by Persons with Business Experience), which include:

(a) Service Corps of Retired Executives (SCORE) Title III, Section 302.

(b) Active Corps of Executives (ACE) Title III, Section 302.

Stat. Auth.: ORS 411.060, 411.070, 411.700, 411.816, 414.042, 412.049

Stats. Implemented: ORS 411.060, 411.070, 411.700, 411.816, 414.042, 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0220

Home

(1) Home defined: A home is the place where the filing group (see OAR 461-110-0310) lives. A home may be a house, boat, trailer, mobile home, or other habitation. A home also includes the following:

(a) Land on which the home is built and contiguous property.

(A) In all programs except the OSIP, OSIPM, QMB, and SNAP programs, property must meet all the following criteria to be considered contiguous property:

(i) It must not be separated from the land on which the home is built by land owned by people outside the financial group (see OAR 461-110-0530).

(ii) It must not be separated by a public right-of-way, such as a road.

(iii) It must be property that cannot be sold separately from the home.

(B) In the OSIP, OSIPM, QMB, and SNAP programs, contiguous property is property not separated from the land on which the home is built by land owned by people outside the financial group.

(b) Other dwellings on the land surrounding the home that cannot be sold separately from the home.

(2) Exclusion of home and other property:

(a) For an individual who has an initial month (see OAR 461-001-0000) of long-term care on or after January 1, 2006:

(A) For purposes of this subsection, "child" means a biological or adoptive child who is:

(i) Under age 21; or

(ii) Any age and meets the Social Security Administration criteria for blindness or disability.

(B) The equity value (see OAR 461-001-0000) of a home is excluded if the requirements of at least one of the following subparagraphs are met:

(i) The child (see paragraph (A) of this subsection) of the individual occupies the home.

(ii) The spouse (see OAR 461-001-0000) of the individual occupies the home.

(iii) The equity in the home is $552,000 or less, and the requirements of at least one of the following sub-subparagraphs are met:

(I) The individual occupies the home.

(II) The home equity is excluded under OAR 461-145-0250.

(III) The home is listed for sale per OAR 461-145-0420.

(iv) Notwithstanding OAR 461-120-0330, the equity in the home is more than $552,000 and the individual is unable legally to convert the equity value in the home to cash.

(b) For all other filing groups, the value of a home is excluded when the home is occupied by any member of the filing group.

(c) In the SNAP program, the value of land is excluded while the group is building or planning to build their home on it, except that if the group owns (or is buying) the home they live in and has separate land they intend to build on, only the home in which they live is excluded, and the land they intend to build on is treated as real property in accordance with OAR 461 145 0420.

(3) Exclusion during temporary absence: If the value of a home is excluded under section (2) of this rule, the value of this home remains excluded in each of the following situations:

(a) In all programs except the OSIP, OSIPM, and QMB-DW programs, during the temporary absence of all members of the filing group from the property, if the absence is due to illness or uninhabitability (from casualty or natural disaster), and the filing group intends to return home.

(b) In the OSIP, OSIPM, and QMB-DW programs, when the individual is absent to receive care in a medical institution, if one of the following is true:

(A) The absent individual has provided evidence that the individual will return to the home. The evidence must reflect the subjective intent of the individual, regardless of the individual's medical condition. A written statement from a competent individual is sufficient to prove the intent.

(B) The home remains occupied by the individual's spouse, child, or a relative dependent on the individual for support. The child must be less than 21 years of age or, if over the age of 21, blind or an individual with a disability as defined by SSA criteria.

(c) In the REF, REFM, and TANF programs, when all members of the filing group are absent because:

(A) The members are employed in seasonal employment and intend to return to the home when the employment ends; or

(B) The members are searching for employment, and the search requires the members to relocate away from their home. If all members of the filing group are absent for this reason, the home may be excluded for up to six months from the date the last member of the filing group leaves the home to search for employment. After the six months, if a member of the filing group does not return, the home is no longer excluded.

(d) In the SNAP program, when the financial group is absent because of employment or training for future employment.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.404, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 410.010, 410.020, 410.070, 410.080, 411.060, 411.070, 411.404, 411.816, 412.049, 413.085, 414.685, 414.839

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 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; 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 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 42-2010(Temp), f. 12-30-10, cert. ef. 1-1-11 thru 6-30-11; SSP 17-2011, f. & cert. ef. 7-1-11; 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 8-2013, f. & cert. ef. 4-1-13; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0230
Housing and Urban Development

(1) Payments from HUD made to a third party in behalf of the client are treated as follows:

(a) In the REF, REFM, and TANF programs, the payment is used to determine shelter-in-kind income.

(b) In the EA, ERDC, OSIP, OSIPM, QMB, and SNAP programs, the payments are excluded.

(2) HUD payments made directly to a member of the financial group, except Youthbuild Program payments and Family Investment Centers payments, are treated as follows:

(a) In the REF, REFM, and TANF programs, the payment is used to determine shelter-in-kind income. If the payments are made in a lump sum, the lump sum is unearned income.

(b) In the EA program, the payment is unearned income.

(c) In the ERDC, OSIP, OSIPM, and QMB programs, the payments are excluded.

(d) In the SNAP program, payments for utilities are excluded. Other payments are unearned income.

(3) Youthbuild Program payments are treated as follows:

(a) In the TANF program, if the Youthbuild Program participant is a dependent child in the filing group or a caretaker relative age 19 or younger, the payments are excluded. If the participant is a caretaker relative over age 19, the payments are treated as follows:

(A) Incentive payments that are reimbursements for specific expenses not covered by program benefits, for instance transportation and school supplies, are excluded.

(B) On-the-job training (OJT) and work experience payments are earned income.

(C) The bonus payment (the incentive payment for attendance) is unearned income.

(b) In the ERDC program, Youthbuild payments are earned income.

(c) In the SNAP program, payments to clients under the age of 19 years who are under the control of an adult member of the filing group are excluded. Other Youthbuild payments are earned income.

(4) Escrow accounts established for families participating in the Family Self-Sufficiency (FSS) program sponsored by HUD are excluded.

(5) Payments related to family investment centers issued under the Cranston-Gonzalez National Affordable Housing Act, Pub. L. No. 101-625, sec. 515, 104 Stat. 4196 (1990), are treated as follows:

(a) Wages are earned income, and stipends are unearned income.

(b) Service payments for items such as child care, basic education, literacy, or computer skills training are excluded.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.049

Stats. Implemented: ORS 411.060, 411.404, 411.816, 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 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; 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 16-1996, f. 4-29-96, cert. ef. 5-1-96; AFS 34-1996, f. 9-26-96, cert. ef. 10-1-96; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 9-2001, f. & cert. ef. 6-1-01; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0240
Income-Producing Sales Contract

(1) The equity value (see OAR 461-001-0000) of an income-producing sales contract is treated as follows:

(a) In the OSIPM and QMB-DW programs for contracts originating on or after October 1, 2012:

(A) Except for a contract resulting from the sale of a home, that is treated in accordance with paragraph (B) of this subsection, it is a countable (see OAR 461-001-0000) resource valued at the outstanding principal balance of the contract unless the individual provides convincing evidence of a lower cash value or there is a legal bar to the sale of the contract. If there is a legal bar to the sale of the contract, the equity value of the contract is a transfer of assets (OAR 461-140-0210 to 461-140-0300 regulate the effect of a transfer of assets on a client) for less than fair market value (see OAR 461-001-0000).

(B) The equity value of a contract resulting from the sale of a home is excluded if the entire principal portion of the payments received from the contract is used to purchase another home within three calendar months of receipt of the payments. Otherwise the equity value is treated in accordance with paragraph (A) of this subsection.

(b) Except as provided for in subparagraph (a) of this section, it is excluded.

(2) In all programs, income received from a sales contract is treated as provided in OAR 461-145-0460.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 410.070, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685, 414.839

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0250

Income-Producing Property; Not OSIP, OSIPM, or QMB

(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 and ERDC 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 (see OAR 461-001-0000) 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 REF, REFM, and TANF programs, it is counted as a resource, except that in the TANF program, it is excluded for a self-employed client participating in the microenterprise (see OAR 461-001-0025) component of the JOBS program.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.083, 411.400, 411.404, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.083, 411.400, 411.404, 411.816, 412.049, 413.085, 414.685

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; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0259

Indian (Native American) Benefits; OSIP, OSIPM, and QMB

(1) The following Indian (Native American) benefits are excluded from income and resources:

(a) Indian lands held jointly with the tribe, or land that may not be sold without the approval of the Bureau of Indian Affairs (BIA).

(b) Payments made under the Indian Judgment Funds Distribution Act (Public Law 93-134).

(c) Distribution of Indian Judgment Funds (Public Law 97-458).

(A) Indian judgment funds include interest and investment income accrued while the funds are held in trust.

(B) Initial purchases made with distributed judgment funds are excluded from resources.

(d) Per capita distributions of all funds held in trust by the Secretary of the Interior to members of an Indian tribe (Public Law 98-64).

(e) The following items received from a native corporation are excluded under the Alaska Native Claims Settlement Act (ANCSA) (Public Law 100-241):

(A) Cash received from a native corporation, including cash dividends on stock received from a native corporation, to the extent it does not exceed $2,000 per individual per year.

(B) Stock, including stock issued or distributed by a native corporation as a dividend or distribution on stock.

(C) A partnership interest.

(D) Land or an interest in land, including land or an interest in land received from a native corporation as a dividend or distribution on stock.

(E) An interest in a settlement trust.

(f) Up to $2000 per year received from payments from individual interests in Trust or Restricted Lands (Public Law 103-66).

(g) Distribution of Per Capita Funds to the Red Lake Band of Chippewa Indians from the proceeds of the sale of timber and lumber on the Red Lake Reservation (Public Law 85-794).

(h) Distribution of Per Capita Funds by the Blackfeet and Gros Ventre tribal governments to members, which resulted from judgment funds to the tribes (Public Law 92-254).

(i) Distribution of Claims Settlement Funds to members of the Hopi and Navajo Tribes (Public Laws 93-531 and 96-305).

(j) Receipts and distributions derived from lands held in trust for Indian tribes are excluded from the following Indian groups (Public Law 94-114):

(A) Seminole Indians.

(B) Pueblos of Zia and Jimenez.

(C) Stockbridge Munsee Indian Community.

(D) Burns Indian Colony.

(E) Assiniboine and Sioux Tribe.

(F) Bad River Band of the Lake Superior Tribe of Chippewa Indians.

(G) Blackfeet Tribe of Montana.

(H) Cherokee Nation of Oklahoma.

(I) Cheyenne River Sioux Tribe.

(J) Crow Creek Sioux Tribe.

(K) Devil's Lake Sioux Tribe.

(L) Fort Belknap Indian Community.

(M) Keweenaw Bay Indian Community.

(N) Lac Courte Oreilles Band of Lake Superior Chippewa Indians.

(O) Lower Brule Sioux Tribe.

(P) Minnesota Chippewa Tribe.

(Q) Navajo Tribe.

(R) Oglala Sioux Tribe.

(S) Rosebud Sioux Tribe.

(T) Shoshone-Bannock Tribe.

(U) Standing Rock Sioux Tribe.

(k) Judgment funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation (Public Law 94-189).

(l) Judgment funds distributed per capita to, or held in trust for, members of the Grand River Band of Ottawa Indians (Public Law 94-540).

(m) Judgment funds distributed per capita to members of the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (Public Law 95-433).

(n) Receipts derived from trust lands awarded to the Pueblo of Santa Ana and distributed to members of that tribe (Public Law 95-498).

(o) Receipts derived from trust lands awarded to the Pueblo of Zia and distributed to members of that tribe (Public Law 95-499).

(p) Judgment funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma (Public Law 96-318).

(q) Funds and distributions to members of the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians under the Maine Indian Claims Settlement Act (Public Law 96-420).

(r) Distributions of judgment funds to members of the San Carlos Tribe of Arizona (Public Law 97-95).

(s) Distributions of judgment funds to members of the Wyandot Tribe of Indians of Oklahoma (Public Law 97-371).

(t) Distributions of judgment funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band of Shawnee descendants) (Public Law 97-372).

(u) Judgment funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana (Public Law 97-376).

(v) Distributions of judgment funds to members of the Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community, and the Jamestown Band of Clallam Indians) (Public Law 97-402).

(w) Judgment funds distributed per capita or made available for programs for members of the Pembina Chippewa Indians (Turtle Mountain Band, Chippewa Cree Tribe, Minnesota Chippewa Tribe, and Little Shell Band of Chippewa Indians of Montana) (Public Law 97-403).

(x) Per capita distributions of judgment funds to members of the Gros Ventre and Assiniboine Tribes of Fort Belknap Indian Community, and the Papago Tribe of Arizona (Public Law 97-408).

(y) Up to $2,000 of per capita distributions of judgment funds to members of the Confederated Tribes of the Warm Springs Reservation (Public Law 97-436).

(z) Judgment funds distributed to the Red Lake Band of Chippewa Indians (Public Law 98-123).

(aa) Funds distributed per capita or family interest payments for members of the Assiniboine Tribe of the Fort Belknap Indian Community

of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana (Public Law 98-124).

(bb) Judgment funds and income therefrom distributed to members of the Shoalwater Bay Indian Tribe (Public Law 98-432).

(cc) All distributions to heirs of certain deceased Indians under the Old Age Assistance Claims Settlement Act (Public Law 98-500).

(dd) Judgment funds distributed per capita or made available for any tribal program, for members of the Wyandotte Tribe of Oklahoma and the Absentee Wyandottes (Public Law 98-602).

(ee) Per capita and dividend payment distributions of judgment funds to members of the Santee Sioux Tribe of Nebraska, the Flandreau Santee Sioux Tribe, and the Prairie Island Sioux, Lower Sioux, and Shakopee Mdewakanton Sioux Communities of Minnesota (Public Law 99-130).

(ff) Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi (Public Law 99-146).

(gg) Distributions of claims settlement funds to members of the White Earth Band of Chippewa Indians as allottees, or their heirs (Public Law 99-264).

(hh) Payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the Saginaw Chippewa Indian Tribe of Michigan (Public Law 99-346).

(ii) Judgment funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi (Public Law 99-377).

(jj) Judgment funds distributed to members of the Cow Creek Band of Umpqua Tribe of Indians (Public Law 100-139).

(kk) Per capita restitution payments made to eligible Aleuts who were relocated or interned during World War II (Public Law 100-383).

(ll) Per capita payments of claims settlement funds to members of the Coushatta Tribe of Louisiana (Public Law 100-411).

(mm) Funds distributed per capita for members of the Hoopa Valley Indian Tribe and the Yurok Indian Tribe (Public Law 100-580).

(nn) Judgment funds held in trust by the United States, including interest and investment income accruing on such funds, and judgment funds made available for programs or distributed to members of the Wisconsin Band of Potawatomi (Hannahville Indian Community and Forest County Potawatomi) (Public Law 100-581).

(oo) All funds, assets, and income from the trust fund transferred to the members of the Puyallup Tribe under the Puyallup Tribe of Indians Settlement Act of 1989 (Public Law 101-41).

(pp) Judgment funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida, plus any interest and investment income accruing on the funds held in trust (Public Law 101-277).

(qq) Payments, funds, distributions, or income derived from them under the Seneca Nation Settlement Act of 1990 (Public Law 101-503).

(rr) Per capita distributions of settlement funds under the Fallon Paiute Shoshone Indian Tribes Water Rights Settlement Act of 1990 (Public Law 101-618).

(ss) Settlement funds, assets, income, payments or distributions from Trust Funds to members of the Catawba Indian Tribe under the Catawba Indian Tribe of South Carolina Land Claims Settlement Act of 1993 (Public Law 103-116).

(tt) Settlement funds held in trust, including interest and investment income accruing on such funds, and payments made to members of the Confederated Tribes of the Colville Reservation under the Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act (Public Law 103-436).

(uu) Payments made or benefits granted by the Crow Boundary Settlement Act of 1994 (Public Law 103-444).

(vv) Per capita distribution judgment funds to members of the Western Shoshone Indians (Public Law 108-270).

(ww) Payments made or granted to the Aroostook Band of Micmacs under Public Law 102-171.

(xx) Payments made from the distribution of judgment funds to members of the Confederated Tribes of the Umatilla under Public Law 91-259.

(yy) Payments from the Tribal Trust Accounting and Management Lawsuits under Public Law 111-291, section 101.

(2) Bureau of Indian Affairs (BIA) General Assistance payments are federally-funded income based on need and are counted as unearned income, regardless of whether they are paid in cash or in kind. The $20 per month general income exclusion does not apply to these payments.

(3) Individual Indian Money (IIM) accounts are treated as follows:

(a) For an account that requires BIA Authorization for withdrawal (restricted):

(A) A deposit required by the BIA is excluded as income and as a resource.

(B) A deposit not required by the BIA is counted or excluded as income in accordance with this chapter of rules based on the source of the deposit. The deposit is excluded as a resource.

(C) A withdrawal is treated in accordance with this chapter of rules based on the source of the funds withdrawn. When funds in the account include both excluded and non-excluded funds, the Department presumes that the non-excluded funds are withdrawn first.

(b) For an account that does not require BIA authorization for a withdrawal (unrestricted): Deposits and withdrawals are treated in accordance with this chapter of rules based on the source of the deposit or withdrawal. When funds in the account include both excluded and non-excluded funds, the Department presumes that the non-excluded funds are withdrawn first.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.083, 411.404, 413.085, 414.685
Stats. Implemented: ORS 409.010, 409.050, 410.010, 410.020, 410.070, 411.060, 411.070, 411.083, 411.404, 413.085, 414.685, 414.839
Hist.: SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0260
Indian (Native American) Benefits; Not OSIP, OSIPM, and QMB

(1) The following Indian (Native American) benefits are excluded:

(a) Indian lands held jointly with the tribe, or land that may not be sold without the approval of the Bureau of Indian Affairs (BIA).

(b) Payments to Puyallup Tribe members from the trust funds established under Public Law 101-41.

(c) Payments from the Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act (Public Law 103-436).

(2) Payments from the BIA are treated as follows:

(a) In the SNAP program, payments from the General Assistance program are counted as unearned income.

(b) In all programs except the SNAP program, payments from the General Assistance program are excluded.

(c) The treatment of educational income is covered by OAR 461-145-0150.

(3) Payments under Public Law 92-203 (Alaska Native Claim Settlement Act) are treated as follows:

(a) In the SNAP program, the entire payment is excluded.

(b) In all programs except the SNAP program:

(A) Only the tax-exempt portion of the payment is excluded.

(B) The remainder of the payment is counted as unearned income.

(4) The following types of distributions provided under Public Law 100-241 (Alaska Native Claim Settlement Act) are excluded:

(a) Stock.

(b) A partnership interest.

(c) Land or interest in land.

(d) An interest in a settlement trust.

(e) The first $2,000 of each per-capita payment per year for each member of the financial group (see OAR 461-110-0530) who receives the payment. The amount over $2,000 paid to each member of the financial group who receives the per-capita payment is counted as lump-sum income (see OAR 461-001-0000 and 461-140-0120).

(5) The Department excludes Indian benefit payments when federal law requires an exclusion. These include payments under each of the following federal laws:

(a) The Aroostook Band of Micmacs under Public Law 102-171.

(b) Blackfeet, Cherokee, Cheyenne, Chippewa, and Sioux tribes under Public Law 94-114, when the payment is from submarginal land held in trust by the United States.

(c) Blackfeet Indians under Public Law 92-254.

(d) Grand River Ottawa Indians under Public Law 94-540.

(e) Hopi or Navajo Indians under Public Law 93-531.

(f) Passamaquoddy Tribe and Penobscott Nation, including the Holton Band of Maliseet Indians, under the Indian Claims Settlement Act (Public Law 96-420).

(g) Umpqua Tribe Cow Creek Band under Public Law 100-139.

(h) Yakima Nation Confederated Tribes and Bands of the Mescalero Reservation Apache Tribe under Public Law 95-433.

(6) Except in the SNAP program, payments received from trust or restricted lands under Public Law 93-134, Public Law 97-458, and Public Law 103-66 are excluded. In the SNAP program, payments received from trust or restricted lands under 25 USC 1408 (Public Law 93-134, Public Law 97-458, and Public Law 103-66) are treated as follows:

(a) Excluded as a resource.

(b) The first $2,000 of each per-capita payment per year for each member of the financial group who receives the payment is excluded as income.

(c) The amount over $2,000 per year paid to any member of the financial group is counted as periodic income (see OAR 461-001-0000 and 461-140-0110).

(7) Payments to Seminole Tribe members under Public Law 101-277 are treated as follows:

(a) The first $2,000 of each per-capita payment per year is excluded for each member of the financial group who receives the payment.

(b) The amount over $2,000 paid to each member of the financial group who receives the per-capita payment is counted as lump-sum income (see OAR 461-140-0120).

(8) Payments from the distribution of judgment funds to members of the Confederated Tribes of the Umatilla under Public Law 91-259 are treated as follows:

(a) The first $2,000 of each per-capita payment per year is excluded for each member of the financial group who receives the payment.

(b) The amount over $2,000 paid to each member of the financial group who receives the per-capita payment is counted as lump-sum income (see OAR 461-140-0120).

(9) Payments for assets held in trust to the Sac and Fox Tribe of Oklahoma and Sac and Fox Tribe of the Mississippi in Iowa by the Indian Claims Commission under Public Law 94-189, Section 6 (The Sac and Fox Indian Claims Agreement) are treated as follows:

(a) The first $2,000 of each per-capita payment per year is excluded for each member of the financial group who receives the payment.

(b) The amount over $2,000 paid to each member of the financial group who receives the per-capita payment is counted as lump-sum income (see OAR 461-140-0120).

(10) Payments from judgment funds held in trust by the U.S. Secretary of the Interior under Public Law 98-64 are excluded.

(11) Indian Child Welfare payments under Public Law 95-608 are excluded.

(12) Tribal payments for child care are treated as follows:

(a) Provider-direct payments are counted as the provider's earned income.

(b) All client-direct payments are excluded.

(13) Indian benefit payments distributed by the tribe and not excluded for that program by public law are counted as unearned income.

(14) Payments in the tribal-TANF program are counted in the same manner as TANF program payments under OAR 461-145-0410.

(15) Payments from the Tribal Trust Accounting and Management Lawsuits under Public Law 111-291 (section 101) are treated as follows:

(a) The payments are excluded as income in the month of receipt.

(b) The payments are excluded as a resource for the 12 calendar months following the receipt of the payment as long as they are not commingled with other funds.

Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.404, 411.816, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.083, 411.404, 411.816, 412.014, 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 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 16-1996, f. 4-29-96, cert. ef. 5-1-96; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 28-2012(Temp), f. & cert. ef. 8-7-12 thru 2-3-13; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; 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 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0320
Life Insurance

(1) Benefits paid on a life insurance policy are counted as unearned income in the month received and a resource if retained into the following month. The Department counts benefits as received when the insured individual dies or when the insured individual is eligible for and receives accelerated payments before death, such as when the insured individual has a terminal illness. When the payment is a lump sum due to the death of the insured individual a deduction is allowed, not to exceed $1,500, for the cost of the deceased individual's last illness and burial if these costs were not otherwise insured.

(2) Burial insurance that has cash surrender value is treated in the same manner that this rule treats life insurance.

(3) The value of a life insurance policy is treated as follows:

(a) All term insurance that has no cash surrender value is excluded.

(b) In all programs except OSIP, OSIPM, and QMB-DW, the cash surrender value of the life insurance policy is excluded.

(c) In the OSIP, OSIPM, and QMB-DW programs:

(A) For the purposes of this subsection, the following definitions apply:

(i) "Cash surrender value" means the equity that the policy acquires over time.

(ii) "Dividend" means a payment of surplus company earnings from the insurer.

(iii) "Dividend accumulation" means a dividend left with the insurer to accumulate interest that may be withdrawn without affecting the policy's face value or cash surrender value.

(iv) "Dividend addition" means the amount of insurance purchased with a dividend that increases the policy's death benefit and cash surrender value.

(v) "Face value" means the amount of the death benefit contracted for at the time the policy was purchased and does not include a dividend addition added after purchase of the policy.

(vi) "Viatical settlement" means an agreement allowing a third party to acquire a life insurance policy from a terminally ill individual at an agreed-upon percentage of the life insurance policy's face value.

(B) The cash surrender value of life insurance policies owned by the financial group (see 461-110-0530) is excluded if the total face value of all policies for the insured individual is less than or equal to $1,500. If the total face value of all policies for the insured individual is more than $1,500, the entire cash surrender value is counted as a resource to the owner of the policy. The total face value does not include any dividend addition. A dividend accumulation must count as a resource even if the face value of the policy that generated the dividend accumulation is excluded.

(C) The cash surrender value of a policy acquired through a viatical settlement is excluded.

Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.404, 411.704, 411.706, 411.816, 412.049, 413.085, 414.685
Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.404, 411.704, 411.706, 411.816, 412.049, 413.085, 414.685, 414.839
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 8-1992, f. & cert. ef. 4-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 5-2002, f. & cert. ef. 4-1-02; 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 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 18-2010, f. & cert. ef. 7-1-10: SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0330
Loans and Interest on Loans

(1) This rule covers proceeds of loans, loan repayments, and interest earned by a lender. If the proceeds of a loan are used to purchase an asset, the asset is evaluated under the other rules in this division of rules.

(2) For purposes of this rule:

(a) In the OSIP, OSIPM, and QMB programs:

(A) "Bona fide loan agreement" means an agreement that;

(i) Is enforceable under state law;

(ii) Is in effect at the time the cash proceeds are provided to the borrower; and

(iii) Includes an obligation to repay and a feasible repayment plan.

(B) "Negotiable loan agreement" means a loan agreement in which the instrument ownership and the whole amount of money expressed on its face can be transferred from one person to another (i.e., sold) at prevailing market rates.

(b) In all programs:

(A) "Reverse-annuity mortgage" means a contract with a financial institution (see OAR 461-001-0000) under which the financial institution provides payments against the equity in the home that must be repaid when the homeowner dies, sells the home, or moves.

(B) The proceeds of a home equity loan or reverse-annuity mortgage (see paragraph (A) of this subsection) are considered loans.

(3) For payments that a member of the financial group (see OAR 461-110-0530) receives as a borrower to be treated as a loan:

(a) In the OSIP, OSIPM, QMB, and SNAP programs, there must be an oral or written loan agreement, and this agreement must state when repayment of the loan is due to the lender.

(b) In programs other than the OSIP, OSIPM, QMB, and SNAP programs, there must be a written loan agreement, and this agreement must be signed by the borrower and lender, dated before the borrower receives the proceeds of the loan, and state when repayment of the loan is due to the lender.

(4) Payments for a purported loan that do not meet the requirements of section (3) of this rule are counted as unearned income.

(5) When a member of a financial group receives cash proceeds as a borrower from a loan that meets the requirements of section (3) of this rule:

(a) In all programs, educational loans are treated according to OAR 461-145-0150.

(b) In the ERDC, REF, REFM, SNAP, and TANF programs, the loan is excluded. If retained after the month of receipt, the loan proceeds are treated in accordance with OAR 461-140-0070.

(c) In the OSIP, OSIPM, and QMB-DW programs:

(A) If the loan is a bona fide loan agreement (see paragraph (2)(a)(A) of this rule), the money provided by the lender is not income but is counted as the borrower's resource if retained in the month following the month of receipt (notwithstanding OAR 461-140-0070).

(B) If the loan is not a bona fide loan agreement, the money provided by the lender is counted as income in the month received and is counted as a resource if retained in the month following the month it was received.

(d) In the QMB-BAS, QMB-SMB, and QMB-SMF programs:

(A) If the loan is a bona fide loan agreement, the money provided by the lender is not considered income.

(B) If the loan is not a bona fide loan agreement, the money provided by the lender is counted as income in the month received.

(6) In the OSIPM program, if a client or a spouse of a client uses funds to purchase a mortgage or to purchase or lend money for a promissory note or loan:

(a) In a transaction occurring on or after July 1, 2006:

(A) The balance of the payments owing to the client or spouse of the client is a transfer of assets for less than fair market value (see OAR 461-001-0000), unless all of the following requirements are met:

(i) The total value of the transaction is being repaid to the client or spouse of the client within three months of the client's life expectancy per that person's actuarial life expectancy as established by the Period Life Table of the Office of the Chief Actuary of the Social Security Administration.

(ii) Payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments.

(iii) The contract is not cancelled upon the death of the individual receiving the payments under this transaction.

(B) If the loan results in a disqualification and the disqualification period has been served, payments against the principal and interest are treated as unearned income.

(b) In a transaction occurring before July 1, 2006, or for a transaction occurring on or after July 1, 2006, that does not result in a disqualification in subsection (a) of this section, the loan is treated as follows:

(A) Interest income is treated as unearned income.

(B) The loan is counted as a resource if:

(i) The financial group includes a client in a nonstandard living arrangement (see OAR 461-001-0000) and the client's spouse;

(ii) The transaction is on or after the date of the first continuous period of care (see OAR 461-001-0030); and

(iii) The amount of the loan plus other resources transferred exceeds the largest amount in OAR 461-160-0580(2)(f).

(C) For all other loans:

(i) If the loan is both a negotiable loan agreement (see paragraph (2)(a)(B) of this rule) and a bona fide loan agreement, the loan is counted as a resource valued at the outstanding principal balance.

(ii) If the loan does not qualify under subparagraph (i) of this paragraph, payments against the principal are counted as unearned income.

(7) In the OSIP and QMB-DW programs:

(a) Interest income is treated as unearned income.

(b) If the loan is both a negotiable loan agreement and a bona fide loan agreement, the loan is counted as a resource of the lender valued at the outstanding principal balance.

(c) If the loan does not qualify under subsection (b) of this section, the payments against the principal are counted as income to the lender.

(8) In the QMB-BAS, QMB-SMB, and QMB-SMF programs:

(a) Interest income is treated as unearned income.

(b) Payments against the principal of all loans are excluded as income.

(9) In all programs other than the OSIP, OSIPM, and QMB programs:

(a) The interest payment is counted as unearned income.

(b) The payment of principal is excluded.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685, 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 28-1992, f. & cert. ef. 10-1-92; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 4-2005, f. & cert. ef. 4-1-05; 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 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 23-2008, f. & cert. ef. 10-1-08; [SSP 20-2009(Temp), f. & cert. ef. 7-29-09 thru 1-25-10; Suspended by SSP 26-2009(Temp), f. & cert. ef. 9-1-09 thru 1-25-10]; Administrative correction 2-19-10; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14: SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0340
Lodger Income

(1) Lodger income is the amount a lodger (see OAR 461-001-0000) pays the filing group for room (rent) and board (meals).

(2) Lodger income is counted as follows:

(a) In the REF, REFM, and TANF programs, lodger income not excluded under OAR 461-155-0350 is treated as self employment income.

(b) In all programs except the OSIP, OSIPM, QMB, REF, REFM, and TANF programs, lodger income is treated as self-employment income.

(c) In the OSIP, OSIPM, and QMB programs, lodger income is the amount a member of the household group (see OAR 461-110-0210) pays for the use of a room (rent) with or without board (meals) and is treated as unearned income:

(A) Lodger income may be reduced by the following allowable expenses such as;

(i) Interest and escrow portions of a mortgage payment (at the point the payment is made to the mortgage holder);

(ii) If the home is rented or leased by the financial group, the monthly rent payment;

(iii) Real estate insurance;

(iv) Repairs (such as a minor correction to an existing structure);

(v) Property taxes (if not included in an escrow portion of the mortgage payment);

(vi) Lawn care;

(vii) Snow removal;

(viii) Advertising for tenants; and

(ix) Utilities.

(B) Allowable expenses are prorated based on the number of rooms designated for rent compared to the number of rooms in the house (excluding bathrooms). Basements and attics are counted only if they have been converted to living spaces (such as recreation rooms).

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 16-1990, f. 6-29-90, cert. ef. 7-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 9-2001, f. & cert. ef. 6-1-01; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0360
Motor Vehicle

(1) The value of disability-related apparatus, optional equipment, or low mileage is not considered in determining the fair market value (see OAR 461-001-0000) of an automobile, truck, or van. The fair market value of an automobile, truck, or van is presumed to be the "average trade-in value" established in the National Automobile Dealers Association's (NADA) Used Car Guide, Kelley Blue Book, or similar publication. A client may rebut the presumption with a statement from a car dealer, mechanic, or other reliable source. If the vehicle is not listed in the NADA Used Car Guide, Kelley Blue Book, or a similar publication, the estimate of the value by the client may be accepted unless it appears questionable, in which case additional evidence of the value is required.

(2) Some programs permit an exclusion for a portion of the equity value (see OAR 461-001-0000) for any licensed and unlicensed motor vehicles owned by the financial group (see OAR 461-110-0530):

(a) In the REF, REFM, SNAP, and TANF programs, this exclusion is up to $10,000.

(b) Any remaining equity in that vehicle and the total equity value of all other vehicles is counted as a resource.

(3) In the EA and ERDC programs, all motor vehicles are excluded.

(4) In the OSIP, OSIPM, and QMB-DW programs:

(a) The total value of a vehicle selected by the financial group is excluded if it is used for transportation of the client or a member of the client's household.

(b) The total equity value of any vehicle not excluded under subsection (a) of this section and all other vehicles is counted as a resource.

(5) In the OSIP-EPD and OSIPM-EPD programs, if a vehicle was purchased as an employment and independence expense (see OAR 461-

001-0035) or with moneys from an approved account (see OAR 461-001-0035), the total value of the vehicle is excluded.

Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.117, 411.404, 411.704, 411.706, 411.816, 412.049

Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.117, 411.404, 411.704, 411.706, 411.816, 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 27-1996, 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 19-1997, f. & cert. ef. 10-1-97; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; 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 9-1999, f. & cert. ef. 7-1-99; 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 17-2004, f. & cert. ef. 7-1-04; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0365

National and Community Services Trust Act (NCSTA), including AmeriCorps (other than AmeriCorps VISTA)

(1) The National and Community Service Trust Act (NCSTA) of 1993 (P.L. 103-82) amended the National and Community Service Act (NCSA) of 1990 (P.L. 101-610) that established a Corporation for National and Community Service. The Corporation administers national service programs providing living allowance, educational award, child care, and in-kind benefits.

(2) NCSTA payments, including AmeriCorps (except AmeriCorps VISTA which is covered in OAR 461-145-0110) are treated as follows:

(a) The living allowance (stipend benefits) is excluded.

(b) Educational award and in-kind benefits are excluded.

(c) The child care allowance is treated as follows:

(A) For clients in the ERDC and TANF programs who are eligible for direct provider payment of child care, the allowance is counted as unearned income. The allowance is excluded only if the client already pays the provider. The provider may be paid for only the costs not covered by the allowance.

(B) For clients in the SNAP program who are receiving a child care deduction, the deduction is allowed only for the costs not covered by the allowance.

(C) In all other programs, the allowance is excluded.

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 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 9-1999, f. & cert. ef. 7-1-99; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 38-2015, f. 12-25-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0370

Older Americans Act

(1) In all programs except the SNAP program, benefits under Title III of the Older Americans Act of 1965 (Nutrition Program for the Elderly) are excluded. In the SNAP program, these benefits are considered unearned income.

(2) In all programs except the SNAP program:

(a) A wage or salary paid to persons 55 years of age and older under Title V of the Older Americans Act of 1965 (Experience Works, American Association of Retired Persons, National Association for Spanish-Speaking Elderly, National Council on Aging, National Council on Black Aging, National Council of Senior Citizens, National Urban League, U.S. Forest Service) is considered earned income.

(b) Payments to an individual 55 years of age and older under Title V of the Older Americans Act of 1965 that are not a wage or salary are excluded.

(3) In the SNAP program, payments under Title V of the Older Americans Act of 1965 are excluded.

Stat. Auth.: ORS 411.060 & 411.816

Stats. Implemented: ORS 411.060 & 411.816

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 19-1994, f. & cert. ef. 9-1-94; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0410

Program Benefits

(1) EA and TA-DVS payments are treated as follows:

(a) In the ERDC and SNAP programs, a payment made directly to the client is counted as unearned income. Dual payee and provider-direct payments are excluded.

(b) In all programs except the ERDC and SNAP programs, these payments are excluded.

(2) Employment Payments (see OAR 461-001-0025 and 461-135-1270) are treated as follows:

(a) In the REF, REFM, SNAP, and TANF programs, these payments are counted as unearned income in the month received.

(b) In all programs not covered in subsection (a) of this section, these payments are excluded.

(3) Payments from ERDC and TANF child care are excluded unless the client is the provider.

(4) Payments from the OCCS medical programs, OSIPM, QMB, and REFM programs are excluded.

(5) Payments from JPI (see OAR 461-135-1260) are issued as a food benefit and are excluded.

(6) SNAP payments are treated as follows:

(a) The value of an SNAP benefit is excluded in all programs except the EA program. In the EA program, the value is counted as a resource when determining the emergency food needs of the filing group (see OAR 461-110-0310 and 461-110-0370).

(b) OFSET service payments are excluded.

(7) Benefits from the GA, OSIP (except OSIP-IC), Post-TANF, REF, SFPSS, TANF, and tribal-TANF programs are treated as follows:

(a) In the EA program, these payments are counted as unearned income, except that these payments are excluded for a benefit group (see OAR 461-110-0750) whose emergent need is the result of domestic violence (see OAR 461-001-0000).

(b) In the ERDC program:

(A) Post-TANF payments are excluded.

(B) All other payments are counted as unearned income.

(c) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, these payments are excluded.

(d) In the SNAP program:

(A) These payments are treated as unearned income.

(B) An amount received as a late processing payment is treated as lump-sum income (see OAR 461-001-0000 and 461-140-0120).

(C) Payments made to correct an underpayment are treated as lump-sum income.

(D) Ongoing special needs payments for laundry allowances, special diet or meal allowance, restaurant meals, accommodation allowances, and telephone allowances are treated as unearned income. All other special needs payments are excluded as reimbursements.

(e) In all programs except the EA, ERDC, QMB-BAS, QMB-SMB, QMB-SMF, and SNAP programs:

(A) These payments are excluded in the month received, and any portion remaining following the month of receipt is counted as a resource.

(B) Payments made to correct an underpayment are excluded.

(f) In all programs:

(A) JOBS, REF, and TANF JOBS Plus support service payments are excluded.

(B) For the treatment of JOBS Plus income, see OAR 461-145-0130.

(C) REF and TANF client incentive payments are treated as follows:

(i) Except in the TANF program, the cooperation incentive payment (see OAR 461-135-0210) is counted as unearned income.

(ii) Progress and outcome incentive payments other than in-kind payments are counted as lump-sum income (see OAR 461-140-0120). All other incentives are excluded.

(8) Payments from OSIP-IC are treated as follows:

(a) In the SNAP program, these payments are counted as unearned income and assets held in a contingency fund (see OAR 411-030-0020) are counted as a resource.

(b) In all other programs, these payments and funds held in a contingency fund are excluded.

(9) Pre-TANF program payments are treated as follows:

(a) In the SNAP program, a payment for basic living expenses, made directly to the client, is counted as unearned income. All other payments are excluded.

(b) In all programs except the SNAP program, these payments are excluded.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.014, 412.049

Stats. Implemented: ORS 411.060, 411.404, 411.700, 411.816, 412.014, 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 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 5-1991, f. & cert. ef. 2-1-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 21-1992(Temp), f. 7-31-92, cert. ef. 8-1-92; AFS 32-1992, f. 10-30-92, cert. ef. 11-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 26-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 32-1996(Temp), f. & cert. ef. 9-23-96; 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 9-1997, f. & cert. ef. 7-1-97; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 17-2004, f.

& cert. ef. 7-1-04; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 18-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 10-2007, f. & cert. ef. 10-1-07; 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 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; 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 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0420
Real Property

(1) For purposes of this rule, manufactured and mobile homes and floating homes and houseboats are treated in the same manner as real property (see OAR 461-001-0000).

(2) The applicant has the burden of proof of establishing the fair market value (see OAR 461-001-0000) of real property. Fair market value may be established by any methodology determined to accurately reflect the fair market value of the real property, including the provision of an appraisal or comparative market analysis performed by an impartial individual who is certified or licensed in the applicable jurisdiction.

(3) Real property that is not income-producing or the home of the financial group (see OAR 461-110-0530) is treated as follows:

(a) In the REF, REFM, and TANF programs, the equity value (see OAR 461-001-0000) of all real property that is not excluded under a TANF Interim Assistance agreement is counted as a resource.

(b) In the EA and ERDC programs, real property is excluded.

(c) In the SNAP program, real property is treated as follows:

(A) The equity value of real property is excluded if the financial group is making a good-faith effort to sell the real property at a fair market price.

(B) The equity value of the real property is counted as a resource if the financial group refuses to make a good-faith effort to sell.

(C) The resource is excluded if selling the resource would produce a net gain to the financial group of less than $1,500.

(d) In the OSIP, OSIPM, and QMB-DW programs:

(A) The equity value of real property that was the home of the financial group is excluded if the financial group is making a good-faith effort to sell the real property at a reasonable price, unless the equity value in the home makes the client ineligible under OAR 461-145-0220(2)(a).

(B) The equity value of all other real property is excluded if the financial group is making a good-faith effort to sell the real property at a reasonable price. The equity value is counted after the real property is excluded for nine months unless the failure to sell it is for reasons beyond the reasonable control of the financial group.

(4) The treatment of real property that is income producing is covered in OAR 461-145-0250.

(5) The treatment of the home of the financial group is covered in OAR 461-145-0220.

Stat. Auth.: ORS 411.060, 411.816 & 412.049
Stats. Implemented: ORS 411.060, 411.816 & 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 13-1991, f. & cert. ef. 7-1-91; AFS 2-1994, f. & cert. ef. 2-1-94; 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 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 11-2006(Temp), f. 6-30-06, cert. ef. 7-1-06 thru 9-30-06; 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 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0455
Resettlement and Placement (R&P) Grants

(1) A Reception and Placement (R&P) grant is a payment made by the United States Department of State through a national refugee resettlement agency to a local resettlement agency, refugee sponsor, or refugee. An R&P grant is provided to the resettlement agency to help with the costs of initial resettlement of a refugee in the United States. The resettlement agency provides a part of this grant to the refugee, usually in the refugee's first month after arrival, for the refugee's initial resettlement needs and not for ongoing living expenses.

(2) In the ERDC, REF, REFM, and TANF programs, an R&P grant is excluded from consideration as income or a resource for purposes of determining program eligibility or benefit levels, except as provided in OAR 461-140-0070.

(3) In the SNAP program, any amount paid directly to a SNAP household from an R&P grant is counted as unearned income. For an in-kind payment made directly to a provider by the resettlement agency, see OAR 461-145-0280.

(4) In the OSIP, OSIPM, and QMB programs, an R&P grant determined to be available to the refugee case is considered unearned income.

Stat. Auth.: ORS 411.060, 411.116, 411.404, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.116, 411.404, 411.816, 412.006, 412.049
Hist.: AFS 1-2001(Temp), f. & cert. ef. 1-30-01 thru 3-31-01; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0460
Sale of a Resource

(1) In the ERDC program, all proceeds from the sale of a resource are excluded as income and as a resource.

(2) In the QMB-BAS, QMB-SMB, and QMB-SMF programs:

(a) For the sale of a resource (except a home) originating prior to October 12, 2012:

(A) All proceeds received on a monthly or other periodic basis are counted as unearned income.

(B) All proceeds received on a lump-sum basis are excluded as income.

(b) For the sale of a home originating prior to October 1, 2012 all proceeds are excluded as income.

(c) For a sale of a resource (including a home) originating on or after October 1, 2012:

(A) The interest portion of proceeds is counted as unearned income.

(B) The principal portion of proceeds is excluded as income.

(3) In the REF, REFM, and TANF programs:

(a) Proceeds from the sale of an excluded resource to the extent reinvested in another excluded resource are excluded as income and as a resource.

(b) All proceeds from the sale of the resource are counted as unearned income, unless excluded in subsection (a) of this section.

(4) In all programs except the ERDC, QMB-BAS, QMB-SMB, QMB-SMF, REF, REFM, and TANF programs, proceeds from the sale of a resource are treated as follows:

(a) Proceeds from the sale of a resource (other than a home) received on a monthly or other periodic basis are counted as unearned income, except that in the OSIPM and QMB-DW programs for a sale originating on or after October 1, 2012 all proceeds that are principal are counted as a resource.

(b) Proceeds from the sale of a resource (other than a home) received on a lump-sum basis are treated as follows, except that in the OSIPM and QMB-DW programs for a sale originating on or after October 1, 2012 all proceeds that are interest are treated as unearned income:

(A) If the proceeds are from the sale of an excluded resource, the amount reinvested in another excluded resource is excluded, and the remainder is counted as a resource.

(B) The proceeds from all other sales are counted as a resource. If the proceeds put the benefit group (see OAR 461-110-0750) over the resource limit, the proceeds are counted as periodic or lump sum income (see OAR 461-140-0110 and 461-140-0120).

(c) Proceeds from the sale of the home of the financial group (see OAR 461-110-0530) are excluded for three months if the financial group intends to use the proceeds (subparagraphs (A)(i) and (A)(ii) of this subsection set out the scope of use of excluded proceeds in the OSIP and QMB-DW programs) to buy another home, except as follows:

(A) In the OSIPM (except for clients eligible under OAR 461-135-0771) and QMB-DW programs for a home sold on or after October 1, 2012:

(i) Principal payments, including lump-sum payments, are excluded for three full calendar months from the date of receipt if the financial group intends to use the proceeds to buy another home or for associated costs including:

(I) Downpayments;

(II) Settlement costs;

(III) Loan processing fees and points;

(IV) Moving expenses;

(V) Necessary repairs to or replacement of the new home's structure or fixtures (including roof, furnace, plumbing, built-in appliances) that are identified and documented prior to occupancy; and

(VI) Mortgage payments.

(ii) For the purposes of subparagraph (i) of this paragraph, funds that are obligated by contract during these three full calendar months are also excluded.

(iii) Interest payments are counted as unearned income.

(B) For clients eligible for OSIPM under OAR 461-135-0771, the proceeds from the sale of the financial group's home, if the financial group

intends to use them to buy another home (subparagraphs (A)(i) and (A)(ii) of this subsection set out the scope of use of excluded proceeds), are treated as follows:

(i) For a home sold prior to October 1, 2012, the proceeds are excluded for 12 full calendar months.

(ii) For a home sold on or after October 1, 2012:

(I) Principal payments, including lump-sum payments, are excluded for 12 full calendar months from the date of receipt.

(II) Interest payments are counted as unearned income.

(d) The proceeds from the sale of a home that are not reinvested in another home are counted as a resource, except as follows:

(A) In the OSIPM and QMB-DW programs for a home sold on or after October 1, 2012:

(i) Principal is counted as a resource.

(ii) Interest payments are counted as unearned income.

(B) In the SNAP program, the proceeds are treated as lump-sum income (see OAR 461-001-0000) under OAR 461-140-0120.

(e) In the SNAP program:

(A) Interest received monthly or on another periodic basis from the sale of a home is counted as unearned income.

(B) If a self-employed client sells a work-related asset, including equipment and inventory, the proceeds of the sale are treated as self-employment income (see OAR 461-145-0910).

(5) Costs of the type excluded under OAR 461-145-0920 are subtracted from proceeds counted as income under this rule.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.083, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 410.010, 410.070, 410.080, 411.060, 411.070, 411.083, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685, 414.839

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; 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 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 9-2001, f. & cert. ef. 6-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 24-2014, f. & cert. ef. 10-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0470
Shelter-in-Kind Income

(1) Except as provided in section (2) of this rule:

(a) In the ERDC program, shelter-in-kind (see OAR 461-001-0000) payments are excluded, except earned shelter-in-kind is not excluded in the ERDC program.

(b) In the REF, REFM, and TANF programs, except for child support (see OAR 461-145-0080 and 461-145-0280), shelter-in-kind payments are excluded.

(c) In the SNAP program, shelter-in-kind housing and utility payments are excluded (see OAR 461-145-0130 about exclusion of earned in-kind income), except an expenditure by a business entity for shelter costs (see OAR 461-001-0000) of a principal (see OAR 461-145-0088) is counted as income.

(d) In the OSIP, OSIPM, and QMB programs:

(A) Except as provided in paragraph (C) of this subsection, unearned shelter-in-kind income is treated as follows:

(i) Shelter-in-kind payments from HUD are excluded.

(ii) If the shelter-in-kind includes all housing and utilities, the Shelter-in-Kind Standard for total shelter (see OAR 461-155-0300) is counted as unearned income.

(iii) If the shelter-in-kind includes all housing (utilities are not included), the Shelter-in-Kind Standard for housing costs (see OAR 461-155-0300) is counted as unearned income.

(B) Except as provided in paragraph (C) of this subsection, earned shelter-in-kind income is treated as follows:

(i) If shelter is provided for services related to the employer's trade or business and acceptance of the shelter is a condition of employment, the shelter-in-kind income is treated in accordance with paragraph (A) of this subsection.

(ii) Except as provided in subparagraph (i) of this paragraph, the fair market value (see OAR 461-001-0000) of the shelter is counted as earned income.

(C) In the OSIP and OSIPM programs, when a prorated standard is used (see OAR 461-155-0020 and OAR 461-155-0250) shelter-in-kind income is excluded.

(2) A payment for which there is a legal obligation to pay to a member of the financial group (see OAR 461-110-0530) that is made to a third party for shelter expenses of a member of the financial group is counted as unearned income.

Stat. Auth.: ORS 409.050, 411.060, 411.404, 411.816, 412.014, 412.049

Stats. Implemented: ORS 411.060, 411.404, 411.700, 411.816, 412.014, 412.049, 414.042

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 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0510
SSI

(1) In the ERDC and SNAP programs, if an individual is required by law to receive an SSI benefit through a representative payee, the representative's fee is excluded.

(2) In the ERDC program:

(a) A monthly SSI payment is counted as unearned income.

(b) Lump-sum SSI payments are counted according to OAR 461-140-0120.

(3) In the OSIP (except OSIP-EPD), OSIPM (except OSIPM-EPD), and QMB-DW programs, a retroactive SSI payment is excluded for nine months after the month of receipt. After the nine-month period, any remaining amount is a countable (see OAR 461-001-0000) resource. For the purposes of this section, a payment is retroactive if it is issued in any month after the calendar month for which it is intended.

(4) In the REF, REFM, and TANF programs:

(a) SSI monthly and lump-sum payments are excluded if the recipient will be removed from the financial group (see OAR 461-110-0530) the month following receipt of the payment.

(b) An SSI lump-sum payment is excluded in the month received and the next month.

(5) In the SNAP program:

(a) A monthly SSI payment is counted as unearned income.

(b) A lump-sum SSI payment is excluded.

Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.404, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.404, 411.816, 412.049, 413.085, 414.685, 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 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 39-1996(Temp), f. 11-27-96, cert. ef. 12-1-96; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0540
Trusts

(1) This section applies to all trust funds (see OAR 461-001-0000) in the REF, REFM, SNAP, and TANF programs. It also applies to OSIP, OSIPM, and QMB-DW 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-DW 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-DW programs, trust funds established on or after October 1, 1993, are treated in accordance with sections (5) to (11) of this rule

(4) In the QMB-BAS, QMB-SMB, and QMB-SMF programs:

(a) All trust funds are excluded as a resource.

(b) A payment made from the trust to or for the benefit of the client is counted as unearned income.

(5) 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.

(6) If the trust contains resources or income of another person, only the share attributable to the client is considered available.

(7) Except as provided in section (10) 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.

(8) If the trust is revocable, it is treated as follows:

(a) In all programs except the QMB-BAS, QMB-SMB, and QMB-SMF programs:

(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 excluded as income.

(b) 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.

(9) 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.

(10) Notwithstanding the provisions in sections (1), (3), and (5) to (9) of this rule, the following trusts are not considered in determining eligibility (see OAR 461-001-0000) for OSIPM and QMB-DW:

(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 (see OAR 461-001-0000).

(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.

(11) This section of the rule applies to a trust signed on or after July 1, 2006.

(a) Notwithstanding the provisions of sections (1), (3), and (5) to (9) 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-DW, 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.

(12) In the OSIP, OSIPM, and QMB-DW 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, 411.083, 411.404, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.404, 411.816, 412.049, 413.085, 414.685, 414.839

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; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0600

Work-Related Capital Assets, Equipment, and Inventory

(1) As used in this rule:

(a) "Inventory" means goods that are in stock and available for sale to prospective customers.

(b) "Work-related equipment" means property essential to the employment or self-employment of a financial group (see OAR 461-110-

0530) member. Examples are a tradesman's tools, a farmer's machinery, and equipment used to maintain an income-producing vehicle.

(2) A capital asset (see OAR 461-001-0000), other than work-related equipment (see section (1) of this rule) and inventory (see section (1) of this rule), is treated as follows:

(a) In the ERDC program, the equity value (see OAR 461-001-0000) of a capital asset is treated according to the rules for the asset.

(b) In the SNAP program, a capital asset used in a business is excluded as follows:

(A) Non-farm assets are excluded as long as the financial group is actively engaged in self-employment activities.

(B) Farm assets are excluded until one year after the date the individual quit self-employment as a farmer.

(c) In the REF, REFM, and TANF programs:

(A) For a self-employed client participating in the microenterprise component (see OAR 461-190-0197) of the JOBS program, the value of a capital asset is excluded.

(B) For all other clients, the value of a capital asset is counted according to the rules in this division of rules.

(d) In the OSIP, OSIPM, and QMB-DW programs, a capital asset is excluded.

(3) Work-related equipment is treated as follows:

(a) In the EA, ERDC, OSIP, OSIPM, QMB-DW, and SNAP programs, the equity value of work-related equipment is excluded.

(b) In the REF, REFM, and TANF programs:

(A) For a self-employed client participating in the microenterprise component of the JOBS program, the equity value of the equipment is excluded.

(B) For all other clients, the equity value of the equipment is treated as a resource.

(4) Inventory is treated as follows:

(a) In the EA, ERDC, OSIP, OSIPM, QMB-DW, and SNAP programs, inventory is excluded as long as the client is engaged in self-employment activities.

(b) In the REF, REFM, and TANF programs:

(A) For a self-employed client participating in the microenterprise component of the JOBS program, the wholesale value of inventory remaining at the end of the semi-annual period covered in each income statement (see OAR 461-190-0197), less encumbrances, is counted as a resource.

(B) For all other clients, the wholesale value of inventory remaining at the end of a month, less encumbrances, is counted as a resource.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.117, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685, 414.839

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1999, f. & cert. ef. 7-1-99; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0910

Self-Employment; General; Not OSIP, OSIPM, or QMB

(1) Self-employment income is income resulting from an individual's business, trade, or profession, rather than from a salary or wage paid by an employer. An individual is considered self-employed if the individual meets the criteria in sections (2) or (3) of this rule. Except as noted in section (3) of this rule, for all programs except SNAP, when an individual has established a corporation, determine if the individual is self-employed according to section (2) of this rule. If the individual has more than one self-employment business, trade, or profession, the income from each is determined separately.

(2) Except as provided in OAR 461-145-0250(1), an individual is self-employed for the purposes of this division of rules if the individual:

(a) Is considered an independent contractor by the business that employs the individual; or

(b) Meets at least four of the following criteria:

(A) Is engaged in an enterprise for the purpose of producing income.

(B) Is responsible for obtaining or providing a service or product by retaining control over the means and manner of providing the work or services offered.

(C) Is principally responsible for the success or failure of the business operation by assuming the necessary business expenses and profit or loss risks connected with the operation of the business, and has the authority to hire and fire employees to perform the labor or services.

(D) Is not required to complete an IRS W-4 form for an employer and is not required to have federal income tax or FICA payments withheld from a pay check.

(E) Is not covered under an employer's liability or workers' compensation insurance policy.

(3) Notwithstanding section (2) of this rule:

(a) Homecare Workers (see OAR 411-031-0020) paid by the Department are not self-employed.

(b) Child care providers (see OAR 461-165-0180) paid by the Department, adult foster home providers (see OAR 411-050-0602) paid by the Department, realty agents, and individuals who sell plasma, redeem beverage containers, pick mushrooms for sale, or engage in similar enterprises are considered to be self-employed.

(4) In the ERDC, REF, SNAP, and TANF programs, self-employment income, including income from a microenterprise (see OAR 461-001-0000), is counted prospectively to determine eligibility (see OAR 461-001-0000) as follows:

(a) Self-employment income is annualized when it is:

(A) Received during less than a 12-month period but is intended as a full year's income.

(B) From a business that has operated for a full year and the previous year is representative of what the income and costs will be during the budget month.

(b) Except in the ERDC program, self-employment income is treated as anticipated income when a financial group (see OAR 461-110-0530) begins self-employment and is unable to determine what the income and costs will be during the budget month.

(5) In the REFM program:

(a) Self-employment income is counted only if received in the month of application.

(b) If self-employment income counted in the month of application puts the applicant over the income limits for REFM, the income is calculated according to section (4) of this rule.

(6) When determining the amount of countable (see OAR 461-001-0000) self-employment income, use gross receipts and sales, including mileage reimbursements, before costs.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.006, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.816, 412.006, 412.049, 413.085, 414.685

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; 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 9-1997, f. & cert. ef. 7-1-97; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 1-2005(Temp), f. & cert. ef. 2-1-05 thru 6-30-05; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 5-2005(Temp), f. & cert. ef. 4-1-05 thru 6-30-05; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15; SSP 25-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 29-2015(Temp), f. & cert. ef. 10-1-15 thru 3-28-16; SSP 36-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0920

Self-Employment; Costs That Are Excluded To Determine Countable Income

(1) This rule explains how to determine which costs are excluded from gross self-employment income.

(2) In all programs except the OSIP, OSIPM, and QMB programs, unless prohibited by section (4) of this rule, and subject to the provisions of sections (6) and (7) of this rule and OAR 461-145-0930, the necessary costs of producing self-employment income are excluded from gross sales and receipts including, but not limited to:

(a) Labor (wages paid to an employee or work contracted out).

(b) Materials used to make a product.

(c) In the SNAP program — principal and interest paid to purchase income-producing property (see OAR 461-001-0000), such as real property, equipment, or capital assets. In all other programs, interest paid to purchase income-producing property, such as equipment or capital assets.

(d) Insurance premiums, taxes, assessments, and utilities paid on income-producing property.

(e) Service, repair, and rental of business equipment, including motor vehicles, and property that is owned, leased, or rented.

(f) Advertisement and business supplies.

(g) Licenses, permits, legal, or professional fees.

(h) Transportation costs at 20 cents per mile, if the cost is part of the business expense. Commuting expenses to and from the worksite are not part of the business expense.

(i) Charges for telephone service that are a necessary cost for self-employment.

(j) Meals and snacks provided by family day care providers for children in their care, except the provider's own children. The actual cost of the meals is used if the provider can document the cost. If the provider cannot document the actual cost, the USDA meal reimbursement rates are used.

(k) Materials purchased for resale, such as cosmetic products.

(L) For newspaper carriers, the cost of newspapers, bags, and rubber bands.

(3) In the OSIP, OSIPM, and QMB programs, unless prohibited by section (5) of this rule, and subject to the provisions of sections (6) and (7) of this rule and OAR 461-145-0930, the necessary costs of producing self-employment income are excluded from gross sales and receipts including, but not limited to:

(a) Advertising.

(b) Car and truck expenses.

(c) Commissions and fees.

(d) Contract labor.

(e) Depletion.

(f) Depreciation.

(g) Employee benefit programs.

(h) Insurance, other than health.

(i) Mortgage interest.

(j) Legal and professional services.

(k) Office expenses.

(L) Pension and profit-sharing plans.

(m) Rent or lease of vehicles, machinery, equipment, and other business property.

(n) Repairs and maintenance.

(o) Supplies.

(p) Taxes and licenses.

(q) Travel, meals, and entertainment.

(r) Utilities.

(s) Wages, less employment credits.

(t) Meals and snacks provided by family day care providers for children in their care, except the provider's own children. The actual cost of the meals is used if the provider is able to document the cost. If the provider is unable to document the actual cost, the USDA meal reimbursement rates are used.

(u) Materials purchased for resale, such as cosmetic products.

(v) For newspaper carriers, the cost of newspapers, bags, and rubber bands.

(4) In all programs except the OSIP, OSIPM, and QMB programs, the following costs are not excluded from gross sales and receipts:

(a) Business losses from previous months.

(b) Except in the SNAP program, payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods.

(c) Federal, state, and local income taxes, draws or salaries paid to any financial group member, money set aside for personal retirement, and other work-related personal expenses, such as transportation, personal business, and entertainment expenses.

(d) Depreciation. For purposes of this section, "depreciation" means a prorated lessening of value assigned to a capital asset (see OAR 461-001-0000) based on its useful life expectancy and initial cost.

(e) Costs related to traveling to another area to seek business when there is no reasonable possibility of deriving income from the trip.

(f) Interest or fees on personal credit cards.

(g) Personal telephone charges.

(h) Shelter or utility costs associated with the individual's home, except as authorized by section (6) of this rule.

(5) In the OSIP, OSIPM, and QMB programs, the following costs are not excluded from gross sales and receipts:

(a) Federal, state, and local income taxes.

(b) Costs related to traveling to another area to seek business when there is no reasonable possibility of deriving income from the trip.

(c) Interest or fees on personal credit cards.

(d) Personal telephone charges.

(e) Shelter or utility costs associated with the individual's home, except as authorized by section (6) of this rule.

(6) The exclusions for items used for both business and personal purposes, such as automobiles and a residence, including utilities, are limited by the following subsections:

(a) In the ERDC, OSIP, OSIPM, and QMB programs, the portion of the expense that is for business use only is excluded.

(b) In the SNAP program, costs are excluded for a separate office or shop located on the property used as a home, if the costs are billed separately from the residence. Costs for other items used for both business and personal use are excluded.

(7) If no member of the financial group (see OAR 461-110-0530) has been self-employed for a sufficiently long period to ascertain the costs of self-employment, the costs may be estimated.

(8) For an individual participating in the microenterprise component (see OAR 461-190-0197) of the JOBS program, costs are excluded according to this rule and general accounting principles, as applied by a certified public accountant, bookkeeping firm, or other entity approved by the Department.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.006, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.816, 412.006, 412.049, 413.085, 414.685, 414.839

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 13-1991, f. & cert. ef. 7-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 1-1993, f. & cert. ef. 2-1-93; AFS 19-1993, f. & cert. ef. 10-1-93; 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 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 5-1998(Temp), f. & cert. ef. 3-11-98 thru 5-31-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 24-1998(Temp), f. 11-30-98, cert. ef. 12-1-98 thru 3-31-99; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; AFS 9-2001, f. & cert. ef. 6-1-01; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 1-2005(Temp), f. & cert. ef. 2-1-05 thru 6-30-05; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-145-0930
Self-Employment; Determination of Countable Income

(1) The Department initially determines gross sales and receipts minus any returns and allowances (before excluding or deducting any costs). This rule explains how different programs exclude and deduct costs from self-employment gross sales and receipts.

(2) In the ERDC program, if an individual claims an excludable cost permitted under OAR 461-145-0920, at least 50 percent of gross self-employment income is excluded. The maximum exclusion is the total excludable cost under OAR 461-145-0920.

(3) In the OSIP, OSIPM, QMB, and REFM programs, all costs permitted under OAR 461-145-0920 are excluded.

(4) In the REF program, no costs are excluded.

(5) In the SNAP program, if there are any costs permitted under OAR 461-145-0920, there is a deduction of 50 percent of gross self-employment income.

(6) In the TANF program:

(a) For an individual participating in the microenterprise (see OAR 461-001-0000) component of the JOBS program, costs are excluded according to OAR 461-145-0920 and general accounting principles, as applied by a certified public accountant, bookkeeping firm, or other entity approved by the Department.

(b) For all other individuals, no costs are subtracted (excluded).

Stat. Auth.: ORS 409.050, 411.060, 411.083, 411.404, 411.706, 411.816, 412.006, 412.009, 412.049 & 414.826

Stats. Implemented: ORS 409.050, 411.060, 411.083, 411.404, 411.706, 411.816, 412.006, 412.009, 412.049 & 414.826

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 9-1997, f. & cert. ef. 7-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 5-1998(Temp), f. & cert. ef. 3-11-98 thru 5-31-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 24-1998(Temp), f. 11-30-98, cert. ef. 12-1-98 thru 3-31-99; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; 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 32-2010, f. & cert. ef. 10-1-10; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-150-0050
Prospective Eligibility and Budgeting; OSIP, OSIPM, and QMB

In the OSIP, OSIPM, and all QMB programs, the Department uses prospective eligibility (see OAR 461-001-0000) and budgeting (see OAR 461-001-0000) as follows:

(1) In the OSIP (except OSIP-IC), OSIPM (except OSIPM-IC), and all QMB programs:

(a) For the initial month (see OAR 461-001-0000), the Department uses prospective eligibility and budgeting. Money received from a nonrecurring source before the date of application is excluded as income.

(b) Except for QMB-BAS, QMB-SMB, and QMB-SMF, if any money remains from a non-recurring source after the date of application, it is counted as a resource.

(c) For each ongoing month (see OAR 461-001-0000) the Department uses prospective eligibility and budgeting.

(2) In the OSIP-IC and OSIPM-IC programs, the budget month (see OAR 461-001-0000) is the initial month of eligibility.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.083, 411.404, 413.085, 414.685
Stats. Implemented: ORS 409.010, 409.050, 410.010, 410.070, 410.080, 411.060, 411.070, 411.083, 411.404, 411.706, 413.085, 414.685, 414.839
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 10-2003(Temp) f. & cert. ef. 5-1-03 thru 9-30-03; SSP 26-2003, f. & cert. ef. 10-1-03; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-155-0010
Use of Payment Standards to Establish Need

(1) Need is the amount at the Department's payment standards that represents the client's need for items covered by the benefit.

(2) Special needs are costs in addition to standard allowances.

(3) In the GA program, ongoing special needs are used to determine benefit amount as specified in OAR 461-160-0500.

(4) In the OSIP and OSIPM programs:

(a) The special need described in OAR 461-155-0630(2) is used to determine initial and ongoing eligibility.

(b) Except for individuals whose eligibility is determined based on the special need described in OAR 461-155-0630(2), special needs are used when determining the benefit amount or the client liability.

Stat. Auth.: ORS 411.060, 411.070, 411.816, 414.042, 418.100
Stats. Implemented: ORS 411.060, 411.070, 411.816, 414.042, 418.100
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; 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 17-2004, f. & cert. ef. 7-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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 an individual 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 the TANF benefit group (see OAR 461-110-0750).

(4) In all programs except the TANF program, 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) Individuals receiving long-term care (see OAR 461-001-0000) 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 (see OAR 461-110-0310) 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 (see OAR 461-001-0000) 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 (see OAR 461-001-0000).

(B) Recipients of OCCS Medical Programs (see OAR 461-001-0000), OSIP, OSIPM, QMB, or TANF.

(5) In the TANF program, prorated standards are based on the number of people in the benefit group (see OAR 461-110-0750), 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 benefit group:

(a) Unborns.

(b) Individuals receiving long-term care (see OAR 461-001-0000) 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 (see OAR 461-110-0310 and 461-110-0330) 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 (see OAR 461-001-0000) 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.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.402, 411.404, 411.706, 412.049, 413.085, 414.685
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.402, 411.404, 411.706, 412.049, 413.085, 414.685
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; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 21-2015, f. & cert. ef. 7-1-15; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-155-0210
Payment Standard; GA

In the GA program, the payment standard is as follows: [Table not included. See ED NOTE.]

(1) The Housing Assistance Payment is issued directly to the landlord and is contingent upon the receipt of a signed and valid Rental Agreement.

(2) The Utility Allowance is issued directly to the individual.

(3) The Personal Incidental Fund is issued directly to the individual.

Stat. Auth.: ORS 409.050 & 411.060
Stats. Implemented: ORS 411.010, 411.060, 411.710, 411.730 & 411.740
[ED. NOTE: Table referenced are available from the agency.]
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 17-1993(Temp), f. & cert. ef. 9-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 16-1995(Temp), f. 7-24-95, cert. ef. 8-1-95; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 1-1996(Temp), f. 1-30-96, cert. ef. 2-1-96; AFS 10-1996, f. 3-27-96, cert. ef. 4-1-96; AFS 11-1997(Temp), f. & cert. ef. 8-1-97; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 10-1999, f. 7-29-99, cert. ef. 8-1-99; AFS 19-2000, f. 7-31-00, cert. ef. 8-1-00; AFS 16-2001(Temp), f. & cert. ef. 8-1-01 thru 9-30-01; AFS 22-2001, f. & cert. ef. 10-1-01; 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 10-2005(Temp), f. & cert. ef. 8-29-05 thru 2-25-06; SSP 18-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-155-0360
Pursuit of Cost-Effective Employer Sponsored Health Insurance

(1) This rule applies to the OSIPM program and is for the purpose of applying OAR 461-120-0345.

(2) The Health Insurance Group (HIG) determines if employer sponsored health insurance meets the criteria as cost effective for the purpose of OAR 410-120-1960.

(3) If the insurance is determined to be cost effective and the client or eligible applicant pursues the insurance, HIG will authorize reimbursement of the client or eligible applicant's portion of the premium per OAR 410-120-1960.

(4) If the insurance is determined to be cost effective and the client or eligible applicant fails to pursue cost effective employer sponsored insurance, the Department will apply a penalty per OAR 461-120-0345.

Stat. Auth.: ORS 411.060, 411.404
Stats. Implemented: ORS 411.060, 411.404
Hist.: AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 23-2008, f. & cert. ef. 10-1-08; 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 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 16-2014, f. & cert. ef. 7-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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 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; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-155-0600
Special Need; Home Repairs; OSIP and OSIPM

In the OSIP and OSIPM programs, the Department will authorize a special need payment for home repairs for homeowners or buyers as a one-time special need within the following limits:

(1) The repairs must be needed to remove a physical hazard to the health and safety of the client.

(2) Payment for repairs authorized by this rule:

(a) Is limited to the least expensive means possible;

(b) Cannot exceed $1,000 in any 24-month period; and

(c) When the home is jointly owned, is limited to a percentage of the cost of the repairs equal to the percentage of client ownership.

(3) The repairs must cost less than moving to another home.

(4) Payment is limited to the lowest possible cost that will provide adequate facilities. The client must provide three competitive bids for the repairs, unless there are not three providers of the service in the local area.

(5) Before approving payment for repairs or new installations, the Department must consider the use value and determine whether it is consistent with the service plan for the client to remain in the house.

(6) Providers of the repairs or new installations must ensure that the work being completed meets current building codes.

(7) Repairs or replacements include, but are not limited to:

(a) Electrical wiring that does not constitute conversion to electrical space heating but that is needed:

(A) To avoid condemnation; or

(B) To remove a definite fire or shock hazard as documented by appropriate public officials.

(b) Plumbing — but not including the costs of plumbing items with which the house is not already equipped except that a toilet may be paid for when newly required by the creation or extension of a sewer district. Examples of what plumbing-related items may be covered include:

(A) Toilets and sinks.

(B) Cleaning or replacing septic tanks or cesspools.

(C) Installing sewer connections from house to street--but not sewer installation--if required by the creation of a new sewer district or the extension of an existing district.

(c) Repair or replacement of existing electric pumps for wells needed to continue the water supply. This does not include drilling a new well.

(d) Heating equipment--repair of heating stoves, furnaces and water heaters and, if repair is not possible, replacement with the least expensive adequate equipment.

(e) Repair of roofs.

(f) Repair or replacement of steps and repair of floors.

(8) A client with a life estate is not eligible for this special need allowance. The individual who will benefit from the life estate, following the death of the client, is considered responsible for the home repairs.

Stat. Auth.: ORS 411.060 & 411.070
Stats. Implemented: ORS 411.060 & 411.070
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; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 16-2002(Temp), f. & cert. ef. 11-1-02 thru 4-30-03; SSP 11-2003, f. & cert. ef. 5-1-03; SSP 18-2008(Temp), f. & cert. ef. 8-1-08 thru 1-28-09; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-155-0610
Special Need; Moving Costs; OSIP and OSIPM

For clients who are 18 years of age or older in the OSIP and OSIPM programs:

(1) The Department will authorize payment for the cost of moving a client's household effects as a one-time special need if the requirements of at least one of the following subsections are met:

(a) Moving is essential to provide nonhazardous housing. "Hazardous" housing means a building so deteriorated and unsafe that it is uninhabitable or subject to condemnation. If no official certification to that effect can be obtained, the condition of the dwelling must have been seen by a Department employee and documented in the case record.

(b) The client has been evicted for reasons other than his or her own neglect or failure to make rent or house payments.

(c) The move is a result of domestic violence or protective services.

(d) For a client in a nonstandard living arrangement (see OAR 461-001-0000), the client must move because the level of needed services increases or decreases.

(e) The needs of the client would be better met out of state.

(2) Payment for moving costs authorized by this rule;

(a) May be authorized for not more than one move in any 12-month period;

(b) Is limited to the least expensive means possible; and

(c) Cannot exceed $500 in any 12-month period.

(3) Payments necessary for a one-time move may be made over a period not to exceed 30 consecutive days.

(4) A filing group that has received a payment for moving costs under this rule is not eligible for a moving cost payment again until the first day of the 12th month following the first payment that was made for the most recent month.

Stat. Auth.: ORS 411.060, 411.070, 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 13-1991, f. & cert. ef. 7-1-91; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 16-2002(Temp), f. & cert. ef. 11-1-02 thru 4-30-03; SSP 11-2003, f. & cert. ef. 5-1-03; SSP 18-2008(Temp), f. & cert. ef. 8-1-08 thru 1-28-09; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-155-0620
Special Need; Property Taxes

(1) OSIP and OSIPM clients who are homeowners or buyers are allowed a special need of one year of delinquent real property taxes, penalties and interest, if needed to prevent imminent foreclosure.

(2) Clients who are eligible for the Oregon Property Tax Deferral Program must opt to defer property taxes. If necessary, the state may provide payment for back property taxes, to bring the tax current, to allow clients to defer their ongoing property taxes.

(3) Clients who have not chosen to defer their property taxes, and have failed to pay their property taxes, will not receive a property tax special need payment unless the exception is authorized by the Department's Estates Administration Unit. The exception will be based on the value of the property, the potential of foreclosure and the potential of an Estates Administration Unit recovery of such property.

(4) Imminent foreclosure is indicated by a formal notice of foreclosure.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706 & 411.710
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.706 & 411.710
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 12-1993, f. & cert. ef. 7-1-93; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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 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; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-155-0670
Special Need; Special Diet Allowance

(1) In the OSIP, OSIPM, REF, REFM, SFPSS, and TANF programs, a client is not eligible for a special diet allowance if receiving any of the following:

(a) Room and board.

(b) Residential care facility services or assisted living facility services.

(c) Nursing facility services.

(d) Adult foster care services.

(e) An allowance for restaurant meals.

(f) A commercial food preparation diet.

(2) A REF, REFM, SFPSS, or TANF client, or an OSIP or OSIPM client receiving SSI, having an adjusted income less than the OSIPM program income standard under OAR 461-155-0250, or receiving in-home services is eligible for a special diet allowance if the client meets the following requirements:

(a) The client would be in an imminent life-threatening situation without the diet, as verified by medical documentation from a Department-approved medical authority (see OAR 461-125-0830); and

(b) A nutritionist verifies that the special diet needed exceeds the cost of a regular diet.

(3) The amount of a special diet allowance is calculated as follows:

(a) In the REF, REFM, SFPSS, and TANF programs, the difference between the actual cost of the special diet and a prorated share of the SNAP program benefit for the appropriate number of clients in the benefit group (see OAR 461-110-0750).

(b) In the OSIP and OSIPM programs, the lesser of the following:

(A) The difference between the actual cost of the special diet and the amount provided in the basic standard for food (see OAR 461-155-0250).

(B) A maximum of $300 per month, or an exceptional amount, authorized by the SPD Program Assistance Section, which will not exceed the cost of home IV therapy.

(4) Local management staff must approve the request for a special diet allowance.

(5) Each special diet allowance must be reviewed at six-month intervals.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.706, 412.014, 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 12-1993, f. & cert. ef. 7-1-93; SSP 17-2004, f. & cert. ef. 7-1-04; 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 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-160-0010
Use of Resources in Determining Financial Eligibility

Countable (see OAR 461-001-0000) resources are used to determine eligibility (see OAR 461-001-0000) as follows:

(1) In the EA program, the countable resources of a financial group (see OAR 461-110-0530) are used to reduce benefits.

(2) In the ERDC, QMB-DW, REF, SNAP, and TANF programs, a need group (see OAR 461-110-0630) is not eligible for benefits if the financial group has countable resources above the resource limit (see OAR 461-160-0015).

(3) In the OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) programs, a need group (see OAR 461-110-0630) is not eligible for benefits if the financial group has countable resources above the resource limit (see OAR 461-160-0015).

(a) When a child (see OAR 461-001-0000) is applying, the parental resources (see subsection (b) of this section) are deemed available to the child. The amount deemed available to the child is the amount the parental resources exceed the resource limit (see OAR 461-160-0015) of:

(A) A one person need group, if one parent (see OAR 461-001-0000) lives in the child's household; or

(B) A two person need group, if two parents (or one parent and the spouse (see OAR 461-001-0000) of that parent) live in the child's household.

(b) As used in this section, "parental resources" means the countable resources of:

(A) Each parent in the child's financial group, and

(B) Each spouse of a parent in the child's financial group.

(c) If more than one child is applying, the value of the deemed resources is divided evenly between the applying children.

(d) The parental resources are not deemed available to an ineligible child.

(e) The value of the parental resources is subject to deeming whether or not those resources are available to the child.

(4) In the OSIP-EPD and OSIPM-EPD programs:

(a) A need group is not eligible for benefits if the financial group has countable resources above the resource limit (see OAR 461-160-0015).

(b) Any money in an approved account (see OAR 461-001-0035) is excluded during the determination of eligibility.

(c) Assets purchased from moneys in an approved account are excluded, provided they meet the requirements of OAR 461-145-0025.

(d) Assets purchased as employment and independence expenses (see OAR 461-001-0035) are excluded, provided they meet the requirements of OAR 461-145-0025.

(5) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, all resources are excluded and have no effect on eligibility (see OAR 461-160-0015).

Stat. Auth.: ORS 411.060, 411.070, 411.400, 411.404, 411.816, 412.049, 413.085, 414.685
Stats. Implemented: ORS 411.060, 411.070, 411.117, 411.400, 411.404, 411.816, 412.049, 413.085, 414.685, 414.839
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 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 17-1998, f. & cert. ef. 10-1-98; 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 9-1999, f. & cert. ef. 7-1-99; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 9-2013(Temp), f. & cert. ef. 4-10-13 thru 10-7-13; SSP 24-2013, f. & cert. ef. 10-1-13; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-160-0015
Resource Limits

(1) In the EA program, all countable (see OAR 461-001-0000) resources must be used to meet the emergent need.

(2) In the ERDC program, the limit is $1,000,000.

(3) In the REFM program, there is no resource limit.

(4) In the OSIP and OSIPM programs, the resource limit is as follows:

(a) $2,000 for a one-person need group (see OAR 461-110-0630) and $3,000 for a two-person need group.

(b) $1,000 for an OSIP need group eligible under OAR 461 135 0771. The total cash resources may not exceed $500 for a one-person need group or $1,000 for a two-person need group.

(c) $5,000 for the OSIP-EPD and OSIPM-EPD programs (see OAR 461-001-0035 and 461-145-0025 for funds that may be excluded as approved accounts).

(5) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, all resources are excluded.

(6) In the QMB-DW program, the resource limit is amended in January of each year based on the low income subsidy for Medicare Part D as published by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Effective January 1, 2015 the resource limit is $7,280 for a one-person need group and $10,930 for a need group containing two or more individuals.

(7) In the REF program, the resource limit is:

(a) $2,500 for any of the following:

(A) A new REF applicant for benefits.

(B) REF need group that has at least one mandatory (see OAR 461-130-0305) participant in an employment program who is:

(i) Receiving REF and not progressing in a required activity of an open case plan; or

(ii) Serving a current employment program disqualification (see OAR 461-130-0330).

(b) $10,000 for a need group not covered under subsection (a) of this section.

(8) In the SNAP program, the resource limit is:

(a) $3,250 for a financial group (see OAR 461-110-0530) with at least one member who is elderly (see OAR 461-001-0015) or an individual with a disability (see OAR 461-001-0015).

(b) $2,250 for all other financial groups.

(9) In the TANF program, the resource limit is:

(a) $2,500 for any of the following:

(A) A new TANF applicant for benefits.

(B) TANF need group that does not have at least one caretaker relative (see OAR 461-001-0000) or parent (see OAR 461-001-0000) who is receiving TANF.

(C) TANF need group that has at least one JOBS participant who is:

(i) Receiving TANF and not progressing in an activity (see OAR 461-001-0025) of an open JOBS case plan (see OAR 461-001-0025); or

(ii) Serving a current JOBS disqualification (see OAR 461-130-0330).

(b) $10,000 for a need group not covered under subsection (a) of this section.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.083, 411.404, 411.706, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.083, 411.404, 411.704, 411.706, 411.816, 411.837, 412.049, 413.085, 414.685, 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 13-1991, f. & cert. ef. 7-1-91; AFS 20-1991, f. & cert. ef. 10-1-91; 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 23-1994, f. 9-29-94, cert. ef. 10-1-94; 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 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 27-1996, 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 10-1998, f. 6-29-98, cert. ef. 7-1-98; 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 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 17-2003, f. & cert. ef. 7-1-03; 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 17-2004, f. & cert. ef. 7-1-04; SSP 22-2004, f. & cert. ef. 10-1-04; 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 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-1; 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 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 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; 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 27-2013, f. & cert. ef. 10-1-13; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 26-2014(Temp), f. & cert. ef. 10-1-14 thru 3-30-15; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 23-2016, f. 6-28-16, cert. ef. 7-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-160-0055
Medical Costs That Are Deductible; OSIP, OSIPM, and SNAP

(1) This rule applies 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 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 following costs, even if prescribed by a medical practitioner, are not allowable medical deductions:

(a) Costs for and related to medical use of marijuana, including registry identification cards.

(b) Costs for items related to special diets which can be purchased with SNAP benefits including, but not limited to, nutritional drinks and organic foods.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 413.085
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 411.837, 414.685, 414.839
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; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 9-2015(Temp), f. & cert. ef. 3-10-15 thru 9-5-15; SSP 17-2015, f. & cert. ef. 6-30-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-160-0060
Use of Rounding in Calculating Benefit Amount

(1) In the REF and TANF programs, a benefit amount not a whole number of dollars is rounded down to the next lower whole dollar.

(2) In the ERDC program, total countable income is rounded down to the next lower whole dollar. The benefit figures are not rounded.

(3) In the GA, OSIP, OSIPM, and QMB programs, rounding is not used.

(4) In the SNAP program:

(a) Except as provided in subsection (b) of this section, when income and deductions are calculated, a figure ending with less than 50 cents is rounded to the next lower dollar and a figure ending with 50 cents or more is rounded to the next higher dollar.

(b) After multiplying the adjusted income by 30 percent, any amount from 1 to 99 cents is rounded up to the next higher dollar.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.014, 412.049
Stats. Implemented: 411.060, 411.404, 411.816, 412.014, 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 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; 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 10-2002, f. & cert. ef. 7-1-02; 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 5-2009, f. & cert. ef. 4-1-09; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-160-0500
Use of Income to Determine Benefits; GA

In the GA program, the countable and adjusted income of an individual or couple are used to determine benefit amount as follows:

(1) For purposes of this rule, "countable income" is calculated using OSIPM countable income methodology except that in-kind and shelter in-kind income is excluded.

(2) For purposes of this rule, "eligible spouse" means a spouse who is eligible for and receiving OSIPM under 461-125-0370(1)(c).

(3) The "adjusted income" amount for the GA program is calculated as follows:

(a) To determine "adjusted income", deductions from the total countable income of the individual or couple are made in the following order:

(b) One standard deduction of $20 from unearned income.

(A) This deduction may be taken from earned income if the individual has less than $20 in unearned income.

(B) This deduction does not apply to a benefit based on need that is totally or partially funded by the federal government or by a nongovernmental agency.

(c) One standard earned income deduction of:

(A) $65 for an individual who is not blind; or

(B) $85 for an individual who is blind.

(d) An income deduction for documented impairment-related work expenses or blind work expenses for an individual under age 65.

(e) One half of the remaining earned income.

(f) Deductions under a plan for self-support for an individual less than the age of 65.

(4) For a single individual, the benefit amount for housing assistance is determined by subtracting the "adjusted income" of the individual from the one-person payment standard (see OAR 461-155-0010).

(5) For a married individual whose spouse is in the OSIPM household group (see OAR 461-110-0210), the amount for housing assistance is determined as follows:

(a) If the individual is married to and living with someone not considered an "eligible spouse", the "adjusted income" of the couple is subtracted from the one-person standard (see OAR 461-155-0010).

(b) If the individual is married to an "eligible spouse", the "adjusted income" of the couple is subtracted from the two-person payment standard (see OAR 461-155-0010).

(6) The amounts for the Personal Incidental Fund and Utility assistance are not affected by "adjusted income" and are determined as follows.

(a) Single individuals and individuals married to someone not considered an "eligible spouse" receive benefits according to the one-person standard (see OAR 461-155-0010).

(b) If the individual is married to an "eligible spouse" who is in the individual's OSIPM household group, the couple receives benefits according to the two-person standard (see OAR 461-155-0010).

Stat. Auth.: ORS 411.060 & 411.710
Stats. Implemented: ORS 411.060 & 411.710
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 17-1995, f. 7-31-94, cert. ef. 8-1-95; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 10-2002, f. & cert. ef. 7-1-02; 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 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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 an individual 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 individual 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 $60 personal needs allowance for an individual receiving long-term care services.

(B) A $90 personal needs allowance for an individual 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) For an individual who receives home and community-based care:

(i) Except as provided in subparagraph (ii) of this paragraph, the OSIPM maintenance standard.

(ii) For an individual who receives in-home services, the OSIPM maintenance standard plus $500.

(d) A community spouse (see OAR 461-001-0030) monthly income allowance is deducted from the income of the institutionalized spouse (see OAR 461-001-0030) 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. $2,003 is added to the amount over $601 that is needed to pay monthly shelter expenses for the principal residence of the couple. This sum or $2,980.50 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). If an all-inclusive rate covers items that are not allowable shelter expenses, including meals or housekeeping in an assisted living facility, or the rate includes utilities, to the extent they can be distinguished, these items must be deducted from the all-inclusive rate to determine allowable shelter expenses.

(B) Step 2 — Compare maintenance needs allowance with community spouse's countable income. The countable (see OAR 461-001-0000) 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 $2,003. To determine the income allowance of each eligible dependent:

(i) The monthly income of the eligible dependent is deducted from $2,003.

(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 individual and eligible dependents.

(ii) The TANF standard is not reduced by the income of the dependent.

(f) Costs for maintaining a home if the individual 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 individual's dependent.

(h) After taking all the deductions allowed by this rule, the remaining balance is the adjusted income.

(i) The individual's liability is determined as follows:

(A) For an individual receiving home and community-based care (except an individual 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 individual, 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 an individual 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.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.706, 413.085, 414.065, 414.685
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.706, 413.085, 414.065, 414.685
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 thu 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; SSP 25-2013, f. & cert. ef. 10-1-13; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 3-2014, f. 1-31-14, cert. ef. 2-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 17-2014(Temp), f. & cert. ef. 7-1-14 thru 12-28-14; SSP 24-2014, f. & cert. ef. 10-1-14; SSP 4-2015, f. & cert. ef. 1-1-15; SSP 21-2015, f. & cert. ef. 7-1-15; SSP 24-2016, f. 6-29-16, cert. ef. 7-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-165-0030
Concurrent and Duplicate Program Benefits

(1) Except as noted in this rule, an individual may not receive benefits from the Department of the same type (that is, cash, medical, or SNAP benefits) for the same period as a member of two or more different benefit groups (see OAR 461-110-0750) or from two or more separate programs. Except as allowed in subsection (g) of this section, this provision includes a prohibition against an individual receiving TANF concurrently with another cash assistance program funded under Title IV-E of the Social Security Act.

(a) An individual may receive EA, HSP, and TA-DVS benefits and cash payments from other programs for the same time period.

(b) If a GA recipient becomes eligible for the TANF program, the GA recipient may not receive a TANF cash payment for themselves in the month a GA cash payment was received.

(c) A TANF recipient may receive ERDC for a child (see OAR 461-001-0000) in the household group (see OAR 461-110-0210), but who may not be included in the TANF filing group (see OAR 461-110-0310 and 461-110-0330).

(d) A child who is a member of an ERDC benefit group may also be a member of one of the following benefit groups:

(A) An OSIP-AB benefit group.

(B) A TANF benefit group when living with a nonneedy caretaker relative (see OAR 461-001-0000), if the caretaker relative is not the parent (see OAR 461-001-0000) of the child.

(C) A TANF benefit group when living with a needy caretaker relative receiving SSI.

(e) An individual in the SNAP program who leaves a filing group (see OAR 461-110-0310 and 461-110-0370) that includes an individual who abused them and enters a domestic violence shelter (see OAR 461-001-0000) or safe home (see OAR 461-001-0000) for victims of domestic violence (see OAR 461-001-0000) may receive SNAP benefits twice during the month the individual enters the domestic violence shelter or safe home.

(f) A QMB recipient may also receive medical benefits from OSIPM, REFM, MAGI Parent or Other Caretaker Relative, or MAGI Pregnant Woman.

(g) An individual may receive Chafee (see OAR 413-030-0400 to 413-030-0455) and TANF benefits during the same time period. As of January 1, 2013, receipt of both Chafee and TANF benefits will not result in an overpayment.

(h) An individual receiving Employment Payments (see OAR 461-001-0025 and 461-135-1270) who becomes eligible for TANF in the same month may receive both benefits in the same month.

(i) An individual receiving JPI (see OAR 461-135-1260) who becomes eligible for Pre-TANF or TANF in the same month may receive both benefits in the same month.

(2) An individual may not receive benefits of the same type (that is, cash, medical, or SNAP benefits) for the same period from both Oregon and another state or tribal food distribution program, except as follows:

(a) Medical benefits may be authorized for an eligible individual if the individual's provider refuses to submit a bill to the Medicaid agency of another state and the individual would not otherwise receive medical care.

(b) Cash benefits may be authorized for an individual in the Pre-TANF program if benefits from another state will end by the last day of the month in which the individual applied for TANF.

(3) In the SNAP program, each individual who has been included as a member of the filing group in Oregon or another state is subject to all of the restrictions in section (2) of this rule.

(4) An REF or TANF filing group may not receive REF or TANF benefits for the same period of time that an individual in the REF or TANF filing group receives assistance from the Office of Refugee Resettlement Matching Grant Program.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.049, 412.124, 414.025, 414.826, 414.839

Stats. Implemented: ORS 411.060, 411.070, 411.117, 411.404, 411.704, 411.706, 411.816, 412.049, 412.124, 414.025, 414.826, 414.839

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 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 14-1999, f. & cert. ef. 11-1-99; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 10-2007, f. & cert. ef. 10-1-07; 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 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 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 29-2014(Temp), f. & cert. ef. 11-3-14 thru 5-1-15; SSP 12-2015, f. 3-16-15, cert. ef. 4-1-15: SSP 38-2015, f. 12-25-15, cert. ef. 1-1-16; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-165-0050

Dual Payee; When to Use

(1) For OSIP, REF, and TANF, use a dual-payee check for protective payments if the benefit group has shown they are not able to properly manage benefits meant to meet their needs. Issue the dual-payee check in both the name of the client and the name of the service provider.

(2) Issue EA checks for shelter, moving costs, property taxes, and home repairs as dual-payee revolving fund checks. The supervisor or branch manager must authorize an exception to this policy in advance.

(3) To make sure a JOBS or OFSET payment is used to meet a specific need, the branch office may write a dual-payee revolving fund check in the name of both the client and the vendor.

Stat. Auth.: ORS 411.060, 411.070, 411.706, 411.816, 412.006, 412.014, 412.049

Stats. Implemented: ORS 411.060, 411.070, 411.706, 411.816, 412.006, 412.014, 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-165-0120

Benefits for a Client in an Acute Care Hospital

(1) In the REF, REFM, and TANF programs, regular monthly benefits continue when a client enters an acute care hospital. The monthly benefits remain unchanged until the client returns home or enters some other living arrangement. An authorized representative designated by the client or the branch may be used if necessary.

(2) In the ERDC, GA, OSIP, OSIPM, and QMB programs, regular monthly benefits continue if a client will be in the acute care hospital for less than 30 days. If the client will be in the acute care hospital for 30 days or more or until death, the client's needs are determined as if the client were in a nursing facility.

(3) In the SNAP program, regular monthly benefits continue if the client will be in his or her own home 50 percent of the time or more. If the client will be in an institution for more than 50 percent of a calendar month, the client is not eligible for SNAP benefits.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.049

Stats. Implemented: ORS 411.060, 411.404, 411.816, 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-170-0011

Changes That Must Be Reported

(1) A change in employment status is considered to occur as follows:

(a) For a new job, the change occurs the first day of the new job.

(b) For a job separation, the change occurs on the last day of employment.

(2) A change in source of income is considered to occur as follows:

(a) For earned income, the change occurs upon the receipt by the individual of the first paycheck from a new job or the first paycheck reflecting a new rate of pay.

(b) For unearned income, the change occurs the day the individual receives the new or changed payment.

(3) An individual must report, orally or in writing, the following changes:

(a) In the ERDC program, an individual must report the following changes within 10 days of occurrence:

(A) A change in child care provider.

(B) A change in employment status.

(C) A change in mailing address or residence.

(D) A change in membership of the filing group (see OAR 461-110-0350).

(E) A member of the filing group is discharged from the U.S. military and returning from active duty in a military war zone.

(F) A change in income above the ERDC income limit as defined in OAR 461-155-0150(5)(b) that is expected to continue.

(b) In the SNAP program:

(A) An ABAWD (see OAR 461-135-0520) assigned to CRS or SRS who resides in Multnomah or Washington County and is employed must report a change in work hours when work hours are below 20 hours per week.

(B) An individual assigned to CRS must report any of the following changes within 10 days of occurrence:

(i) A change in earned income of more than $100.

(ii) A change in unearned income of more than $50.

(iii) A change in source of income.

(iv) A change in membership of the filing group (see OAR 461-110-0370) and any resulting change in income.

(v) A change in residence and the shelter costs in the new residence.

(vi) A change in the legal obligation to pay child support.

(vii) When the sum of cash on hand, stocks, bond, and money in a bank or savings institution account reaches or exceeds program resource limits.

(viii) Acquisition or change in ownership of a non-excluded vehicle.

(C) An individual assigned to SRS must report when the monthly income of the filing group exceeds the SNAP countable (see OAR 461-001-0000) income limit by the tenth day of the month following the month of occurrence.

(D) An individual assigned to TBA is not required to report any changes.

(c) For JPI (see OAR 461-135-1260), an individual must follow the same reporting requirements as a SNAP client assigned to CRS, SRS, or TBA reporting systems (see OAR 461-170-0010).

(d) In the GA, OSIP, OSIPM, and QMB programs, an individual must report all changes that may affect eligibility (see OAR 461-001-0000) within 10 days of occurrence, including any of the following changes:

(A) A change in employment status.

(B) A change in health care coverage.

(C) A change in membership of the household group (see OAR 461-110-0210).

(D) A change in marital status.

(E) A change in residence.

(F) Except for QMB-BAS, QMB-SMB, and QMB-SMF, a change in resources.

(G) A change in source or amount of income.

(e) In the REF, SFPSS, and TANF programs, an individual assigned to CRS must report any of the following changes within 10 days of occurrence:

(A) Acquisition or change in ownership of a non-excluded vehicle.

(B) A change in earned income more than $100.

(C) Employment separation.

(D) A change in membership of the household group (see OAR 461-110-0210).

(E) A change in marital status or other changes in membership of the filing group.

(F) A change in mailing address or residence.

(G) A change in pregnancy status of any member of the filing group.

(H) A change in source of income.

(I) A change in unearned income more than $50.

(J) A change in who pays the shelter costs if the costs will be paid by a non-custodial parent.

(K) Sale or receipt of a resource that causes total resources to exceed program resource limits.

(f) In the REFM program, an individual must report the following changes within 10 days of occurrence:

(A) A change in membership of the household group (see OAR 461-110-0210).

(B) A change in residence.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.081, 411.404, 411.704, 411.706, 411.816, 411.825, 412.014, 412.049, 413.085, 414.685, 414.826

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1992, f. & cert. ef. 5-1-92; AFS 17-1992, f. & cert. ef. 7-1-92; 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 13-1994, f. & cert. ef. 7-1-94; AFS 19-1994, f. & cert. ef. 9-1-94; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; 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 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 25-1998, f. 12-18-98, cert. ef. 1-1-99; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 11-1999, f. & cert. ef. 10-1-99; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 24-2002(Temp), f. 12-31-02, cert. ef. 1-1-03 thru 6-30-03; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 13-2003, f. 6-12-03, cert. ef. 6-16-03; SPP 20-2003, f. & cert. ef. 8-15-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 16-2005, f. & cert. ef. 12-1-05; 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 10-2007, f. & cert. ef. 10-1-07; 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; Renumbered from 461-170-0015, 461-170-0020, 461-170-0025, 461-170-0030, 461-170-0035 by SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 5-2009, f. & cert. ef. 4-1-09; 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 32-2010, f. & cert. ef. 10-1-10; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 10-2012, f. 3-29-12, cert. ef. 3-30-12; 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 24-2013, f. & cert. ef. 10-1-13; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 14-2014(Temp), f. & cert. ef. 6-26-14 thru 12-23-14; SSP 24-2014, f. & cert. ef. 10-1-14; SSP 23-2015, f. 9-28-15, cert. ef. 10-1-15; SSP 37-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-175-0210

Notice Situation; Client Moved or Whereabouts Unknown

(1) To end benefits for an individual who has moved out of Oregon, the Department sends the following decision notice (see OAR 461-001-0000):

(a) In the ERDC, GA, OSIP, OSIPM, QMB, REF, REFM, and TANF programs:

(A) The Department sends a timely continuing benefit decision notice (see OAR 461-001-0000) to the individual who has moved out of Oregon.

(B) The Department sends a basic decision notice (see OAR 461-001-0000) if the individual becomes eligible for benefits in another state.

(b) For Employment Payments (see OAR 461-001-0025 and 461-135-1270), JPI (see OAR 461-135-1260), and the SNAP program, no decision notice is required if the Department determines that the benefit group (see OAR 461-110-0750) has moved out of Oregon.

(2) If Department mail or benefits have been returned with no forwarding address, the Department gives the individual the benefits if the individual's whereabouts become known during the period covered by the returned benefits. See OAR 461-165-0130 for when SNAP benefits may be sent out of Oregon. If the individual's whereabouts are unknown, the Department ends benefits by sending the following decision notice to their last known address:

(a) Except for Employment Payments, JPI, and the SNAP program, a basic decision notice.

(b) For Employment Payments, JPI, and the SNAP program, no decision notice is required.

Stat. Auth.: ORS 411.060, 411.095, 411.404, 411.816, 412.049

Stats. Implemented: ORS 411.060, 411.095, 411.404, 411.816, 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 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; 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 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 37-2011(Temp), f. 12-30-11, cert. ef. 1-1-12 thru 6-29-12; SSP 22-2012, f. 6-29-12, cert. ef. 6-30-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 33-2013(Temp), f. & cert. ef. 10-3-13 thru 3-30-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 30-2014(Temp), f. & cert. ef. 11-14-14 thru 5-12-15; SSP 12-2015, f. 3-16-15, cert. ef. 4-1-15; SSP 15-2016, f. & cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-175-0240

Notice Situation; Lump-Sum

If a financial group (see OAR 461-110-0530) receives lump-sum income that will make the financial group ineligible or cause a reduction in benefits:

(1) The Department will deny benefits to an applicant and send a basic decision notice (see OAR 461-001-0000).

(2) If a benefit group (see OAR 461-110-0750) is receiving benefits, the Department will stop or reduce them and:

(a) If the action is based on changes reported on the Interim Change Report form, send a continuing benefit decision notice (see OAR 461-001-0000).

(b) If the action is not based on changes reported on the Interim Change Report form, send a timely continuing benefit decision notice (see OAR 461-001-0000).

Stat. Auth.: ORS 411.060, 411.095, 411.816

Stats. Implemented: ORS 411.060, 411.095, 411.816

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; 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 13-1994, f. & cert. ef. 7-1-94; AFS 24-2001, f. & cert. ef. 11-1-01; SSP 20-2003, f. & cert. ef. 8-15-03; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-175-0310

Notice Situation; Resource Transfer Disqualification

(1) When the Department proposes to disqualify a filing group (see OAR 461-110-0310) because of a disqualifying transfer of assets (see OAR 461-140-0210), the following notice is sent:

(a) For new applicants, a basic decision notice (see OAR 461-001-0000).

(b) For ongoing clients, a timely continuing benefit decision notice (see OAR 461-001-0000).

(2) A notice required by this rule includes the amount of uncompensated value used in the eligibility determination and the period of ineligibility caused by the transfer.

(3) In the OSIP and OSIPM programs, the notice must also include:

(a) The action that resulted in the disqualification; and

(b) Information that the individual, or the facility in which the individual resides (on behalf of the individual), may apply for a waiver of the disqualification on the basis of undue hardship.

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070, 411.816, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 410.070, 411.060, 411.070, 411.095, 411.816, 412.049, 413.085, 414.685

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 35-2015, f. 12-23-15, cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-180-0010

Effective Dates; Adding a New Person to an Open Case

(1) In the following programs, the effective date for adding an individual (other than an assumed eligible newborn) to the benefit group (see OAR 461-110-0750) is one of the following:

(a) In the OSIPM program, the date benefits are requested for the individual establishes a date of request (see OAR 461-115-0030) for the individual. The effective date for the individual is determined in accordance with OAR 461-180-0090.

(b) In the REFM program, it is whichever occurs first:

(A) The date the individual requests benefits, if the individual was eligible as of that date.

(B) The date all eligibility requirements are met.

(c) In the SNAP program:

(A) If adding the individual increases benefits, it is the first of the month after the filing group (see OAR 461-110-0310 and 461-110-0370) reports the person has joined the household group (see OAR 461-110-0210). If verification is requested, the effective date for the change is:

(i) The first of the month following the date the change was reported if verification is received by the Department no later than the due date for the verification.

(ii) The first of the month following the date the verification is received by the Department if received after the verification due date.

(B) If adding the individual reduces benefits, it is the first of the month following the month in which the notice period ends (see OAR 461-175-0050).

(d) In the GA, OSIP, REF, SFPSS, and TANF programs, it is the date on which all eligibility requirements are met and verified. If benefits have been issued for the month and adding the new person would reduce benefits, the person is added the first of the month following the month in which the notice period ends (see OAR 461-175-0050).

(e) In the QMB-BAS and QMB-DW programs, it is the first of the month after the new individual has been determined to meet all QMB eligibility criteria and the Department receives the required verification.

(f) In the QMB-SMB program, it is the first of the month in which the new individual has been determined to meet all QMB-SMB eligibility criteria and the Department receives the required verification.

(g) In the SFPSS and TANF programs, for adding a child (see OAR 461-001-0000) to be covered by a provider-direct child care payment, it is the first of the month in which the child is added to the benefit group.

(2) In the following programs, the effective date for adding an assumed eligible newborn to the benefit group is one of the following:

(a) In the OSIPM and REFM programs, it is the date of birth if all the following paragraphs are true. If any of the following paragraphs is not true, the newborn is added to the benefit group in accordance with section (1) of this rule.

(A) A request for benefits is made within one year of the birth. For purposes of this paragraph, a telephone call from the attending physician, another licensed practitioner, a hospital, or the family is considered a request for benefits.

(B) The newborn has continuously lived with the mother since the date of birth.

(C) The mother was receiving OSIPM on the date of birth, even if she is not currently eligible for benefits.

(b) In the SFPSS and TANF programs, it is:

(A) The date of birth, if all eligibility requirements are met and verified within 45 days after the birth; or

(B) The date all eligibility factors are met and verified, if the verification is completed more than 45 days after the date of birth.

(3) In the ERDC program, the effective date for adding an individual to the need group (see OAR 461-110-0630) or benefit group is as follows:

(a) If adding the individual to the need group will decrease the copay, the effective date is the first of the month after the client reports the person has joined the household.

(b) If adding the individual to the need group increases the copay — for instance, because the individual receives income — the effective date is the first of the month following the end of the decision notice period (see OAR 461-175-0050).

(c) The effective date for adding a child to the benefit group — that is, covering the cost of the child's care — is the earliest of the following:

(A) For newborns, the date of birth, if all eligibility requirements are met and verified within 45 days after the birth.

(B) For all other children, the first of the month in which the change is reported, if all eligibility requirements are met and verified within 45 days.

(C) For newborns and other children, if eligibility cannot be verified within 45 days, the effective date is the first of the month in which all eligibility factors are met and verified.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.816, 412.049, 414.042

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.816, 412.049, 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 23-1990, f. 9-28-90, cert. ef. 10-1-90; 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 2-1994, f. & cert. ef. 2-1-94; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; AFS 19-1997, f. & cert. ef. 10-1-97; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 17-2004, f. & cert. ef. 7-1-04; 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 19-2013(Temp), f. 7-31-13, cert. ef. 8-1-13 thru 1-28-14; SSP 28-2013(Temp), f. & cert. ef. 10-1-13 thru 1-28-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 32-2015(Temp), f. & cert. ef. 12-15-15 thru 6-11-16; SSP 4-2016(Temp), f. & cert. ef. 1-22-16 thru 6-11-16; SSP 13-2016, f. 3-21-16, cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-180-0065

Effective Dates; Ending Disqualifications

(1) The effective date for ending a JOBS disqualification or a disqualification related to diagnosis, counseling, or treatment for substance abuse or mental health is:

(a) The date the client meets the requirements for ending the JOBS disqualification (see OAR 461-130-0335); or

(b) The date the client meets the requirements for ending the disqualification for failure to comply with OAR 461-135-0085(1) (see OAR 461-135-0089).

(2) In the OSIPM program, the effective date for ending the disqualification for failing to enroll in cost-effective, employer-sponsored health insurance is the date the client provides verification of enrollment during the open enrollment period.

(3) In the SNAP program, the effective date for ending an employment program disqualification is the date the client fulfills the requirements to end the disqualification or the first of the month following the minimum disqualification period, whichever occurs later (see OAR 461-180-0010 regarding the effective date for adding a person to an open case).

(4) For an IPV disqualification, the disqualification ends the day after the minimum disqualification period ends, if there is no additional IPV disqualification to be served and all eligibility requirements are met.

(5) For all other disqualifications in the TANF program, the disqualification ends whenever the client agrees to cooperate.

(6) For other disqualifications in the SNAP program, the disqualification ends at the end of the disqualification period.

Stat. Auth.: ORS 411.060, 411.816 & 412.049

Stats. Implemented: ORS 411.060, 411.816 & 412.049

Hist.: AFS 22-1990(Temp), f. 9-28-90, cert. ef. 10-1-90; AFS 26-1990, f. & cert. ef. 11-29-90; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 2-1994, f. & cert. ef. 2-1-94; 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 17-1998, f. & cert. ef. 10-1-98; AFS 11-1999, f. & cert. ef. 10-1-99; AFS 12-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-180-0070

Effective Dates; Initial Month Benefits

(1) In the EA program, the effective date for opening the case is the day benefits are issued to the benefit group (see OAR 461-110-0750). For a benefit group whose only eligible child is an unborn, the effective date cannot be earlier than the first day of the calendar month preceding the month in which the due date falls.

(2) In the ERDC program, the effective date for starting benefits is one of the following:

(a) The first day of the month in which the request for benefits is made if:

(A) All eligibility (see OAR 461-001-0000) requirements are met in that month; and

(B) Verification is provided within the application processing timeframes.

(b) If all eligibility requirements are not met in the month of request, the effective date is the first day of the month in which they are met, if verification is provided within the application processing timeframes.

(c) For a benefit group that received TANF program benefits within the 30 days before applying for ERDC program benefits, the effective date is the first of the month following closure of their TANF program benefits.

(3) In the GA program, the effective date for the initial month (see OAR 461-001-0000) of benefits is the first of the month following the day all eligibility requirements are met and verified.

(4) In the OSIP program, the effective date for the initial month of benefits is whichever of the following occurs first:

(a) The date an individual requests benefits, if the individual was eligible as of that date.

(b) The date all eligibility requirements are met.

(5) In the REF program, when a filing group (see OAR 461-110-0430) makes an initial application, the effective date for starting benefits is:

(a) If all eligibility requirements, including an interview, are completed by the 45th day from the date of request (see OAR 461-115-0030), the effective date for starting benefits is the filing date (see OAR 461-115-0040).

(b) If all eligibility requirements are not met by the 45th day from the date of request, a new date of request and filing date must be established.

(6) In the TANF program, when a filing group (see OAR 461-110-0330) makes an initial application or applies after the end of the certification period (see OAR 461-001-0000), the effective date for starting TANF benefits is one of the following:

(a) Except as provided in subsections (b) to (d) of this section, if all eligibility requirements, including a TANF interview, are completed by the 45th day from the date of request, the effective date for starting benefits is the filing date. If all eligibility requirements are not met by the 45th day from the date of request, a new date of request and filing date must be established.

(b) If the only eligible child is an unborn, the effective date may not be earlier than the first day of the calendar month preceding the month in which the due date falls.

(c) For an individual in the Pre-TANF program, the effective date for the initial month of benefits is the date the Pre-TANF program ends as provided in OAR 461-135-0475.

(d) For a JOBS support service payment, the effective date is the date the individual meets all eligibility requirements in OAR 461-190-0211.

(7) In the SFPSS program, when moving a TANF program recipient to SFPSS, the effective date for the initial month of SFPSS program benefits is:

(a) Except as provided in subsection (b) of this section, the first of the month following the day all eligibility requirements are met and verified.

(b) If the day all eligibility requirements are met and verified falls after the "compute deadline," the initial month of SFPSS program benefits will be the first of the month following the month after "compute deadline." For purposes of this rule, "compute deadline" means the Department computer system monthly deadline after which changes will not take effect until the month following the first of the next month.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.878, 412.006, 412.014, 412.049, 413.085, 414.685

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.081, 411.087, 411.404, 411.706, 411.878, 412.006, 412.014, 412.049, 412.064, 413.085, 414.685

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 13-1991, f. & cert. ef. 7-1-91; 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 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; SSP 7-2003, f. & cert. ef. 4-1-03; CWP 37-2003(Temp), f. 10-31-03, cert. ef. 11-1-03 thru 4-28-04; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 21-2004, f. & cert. ef. 10-1-04; 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 23-2008, f. & cert. ef. 10-1-08; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 26-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 3-29-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 17-2015, f. & cert. ef. 6-30-15; SSP 22-2015(Temp), f. & cert. ef. 7-23-15 thru 1-18-16; SSP 28-2015, f. 9-29-15, cert. ef. 10-1-15; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-180-0090

Effective Dates; Initial Month Medical Benefits

The effective date for starting medical benefits for an eligible client is as follows:

(1) In the OSIPM and QMB-DW programs:

(a) Except as provided for in subsections (b) to (h) of this section:

(A) If the client meets all eligibility requirements on the date of request (see OAR 461-115-0030), it is the first day of the month that includes the date of request. An OSIPM program client who is assumed eligible under OAR 461-135-0010(5) meets "all eligibility requirements" for the purposes of this section as follows:

(i) Effective the first day of the month of the initial SSI payment if the client is age 21 or older.

(ii) Effective the first day of the month prior to the month of the initial SSI payment if the client is under the age of 21.

(B) If the client does not meet all eligibility requirements on the date of request, but meets all requirements after the date of request, within the application processing time frames of OAR 461-115-0190, it is the first day of the month that includes the date that all eligibility requirements are met.

(b) If the client does not complete the application within the time period described in OAR 461-115-0190 (including the authorized extension), the determination of an effective date requires a new date of request.

(c) Except as provided for in subsections (d) and (e) of this section, for a new applicant who is an inmate (see OAR 461-135-0950) on any day of the month during the month that the applicant is determined to meet all eligibility requirements, the effective date is determined in accordance with subsections (a) and (b) of this section, except that coverage is not in effect for any day during the month that the applicant is an inmate other than the date of incarceration and the date of release.

(d) The effective date for an individual residing in a public institution (see OAR 461-135-0950) meeting the requirements of OAR 461-135-0950 regarding applications received by individuals with a serious mental illness is determined in accordance with OAR 461-135-0950.

(e) The effective date for an individual meeting the eligibility requirements of OAR 461-135-0950 regarding residents of a state psychiatric institution is the date that all eligibility requirements are met, including other chapter 461 eligibility requirements, if those requirements are met within the application processing time frames of OAR 461-115-0190. Otherwise the requirements of subsection (b) of this section apply.

(f) The effective date for an inmate or a resident of state hospital with suspended benefits that will be reinstated is determined in accordance with OAR 461-135-0950. If benefits will not be reinstated the inmate is considered a new applicant and the effective date is determined in accordance with subsection (c) of this section.

(g) The effective date for a new applicant who is receiving Medicaid in another state on the date of request, but meets the requirements of OAR 461-165-0030 regarding receipt of medical benefits in another state is:

(A) The date of request if all eligibility requirements are met on the date of request or after the date of request, but during the month that includes the date of request.

(B) If all eligibility requirements are not met during the month that includes the date of request the effective date is determined in accordance with paragraph (1)(a)(B) and subsection (b) of this section.

(h) The effective date for an applicant receiving Medicaid in another state prior to the date of request, but during the month that includes the date of request, is the day following the day that Medicaid benefits end in the other state if all eligibility requirements are met during the month that includes the date of request. If all requirements are not met in the month that includes the date of request the effective date is determined in accordance with paragraph (1)(a)(B) and subsection (b) of this section.

(2) In the QMB-BAS program, it is the first of the month after the benefit group (see OAR 461-110-0750) has been determined to meet all QMB-BAS program eligibility criteria and the Department receives the required verification.

(3) In the QMB-SMB and QMB-SMF programs, it is:

(a) The first of the month in which the benefit group meets all program eligibility criteria and the Department receives the required verification; or

(b) The first of the month in which the Low Income Subsidy (LIS) information is received by the Social Security Administration (SSA), if the SMB or SMF program application was generated by the electronic transmission of LIS data from the SSA and the benefit group meets all program eligibility criteria.

(4) In the REFM program:

(a) Except as provided in subsection (b) of this section:

(A) If the individual meets all eligibility requirements on the date of request (see OAR 461-115-0030), it is the date of request.

(B) If the individual does not meet all eligibility requirements on the date of request, it is the first day following the date of request that all eligibility requirements are met.

(b) If the individual does not complete the application within the time period described in OAR 461-115-0190 (including the authorized extension), the determination of an effective date requires a new date of request.

(5) Retroactive eligibility is authorized under certain circumstances in some medical programs (see paragraph (1)(a)(A) of this rule, OAR 461-135-0875, and 461-180-0140).

Stat. Auth.: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.704, 411.706, 413.085, 414.685, 414.839

Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.704, 411.706, 413.085, 414.685, 414.839

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 13-1991, f. & cert. ef. 7-1-91; AFS 1-1993, f. & cert. ef. 2-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 5-2000, f. 2-29-00, cert. ef. 3-1-00; SSP 5-2003, f. 2-26-03, cert. ef. 3-1-03; SSP 23-2003, f. & cert. ef. 10-1-03; 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 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; 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 1-2010(Temp), f. & cert. ef. 1-26-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 20-2010(Temp), f. & cert. ef. 7-1-10 thru 12-28-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 19-2013(Temp), f. 7-31-13, cert. ef. 8-1-13 thru 1-28-14; SSP 28-2013(Temp), f. & cert. ef. 10-1-13 thru 1-28-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 32-2015(Temp), f. & cert. ef. 12-15-15 thru 6-11-16; SSP 4-2016(Temp), f. & cert. ef. 1-22-16 thru 6-11-16; SSP 13-2016, f. 3-21-16, cert. ef. 4-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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, OCCS Medical programs household group (see OAR 410-200-0015), ineligible student, or authorized representative (see OAR 461-115-0090 and OAR 410-200-0015) 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.

(c) In the OCCS Medical programs, if actual income is not available for the months in which an overpayment occurred, a client's actual self-employment income (see OAR 410-200-0015) received during the year when an overpayment occurred is annualized to calculate an 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 using anticipated income for the OCCS Medical programs and the actual income differs from the amount determined under OAR 410-200-0310, there may be a client error overpayment only when the OCCS Medical programs household group (see OAR 410-200-0015) or authorized representative (see OAR 410-200-0015) 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.

(5) 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 (6) of this rule) exists.

(c) In the SNAP program, no deduction is applied to earned income if the amount or source of income was not timely reported.

(6) 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.

(7) 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 (see OAR 461-001-0000). 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.

(8) 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.

(9) 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.

(10) Benefits paid during a required notice period (see OAR 461-175-0050, OAR 410-200-0120) are included in the calculation of the overpayment when:

(a) The filing group, OCCS Medical programs household group (see OAR 410-200-0015), ineligible student, or authorized representative (see OAR 461-115-0090 and OAR 410-200-0015) failed to report a change within the reporting time frame under OAR 461-170-0011 or OAR 410-200-0235; and

(b) Sufficient time existed for the Department to adjust the benefits to prevent the overpayment if the filing group, OCCS Medical program household group (see OAR 410-200-0015), ineligible student, or authorized representative (see OAR 461-115-0090 and OAR 410-200-0015) had reported the change at any time within the reporting time frame.

(11) 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.

(12) 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 461-155-0710; 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.

(13) 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.

(14) In the OCCS Medical programs, OSIPM, QMB, and REFM 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.

(15) 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 OCCS Medical programs, OSIPM, and REFM programs.

(16) 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 in the program in which the overpayment occurred.

(17) 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.]

(18) In the REF program, when an individual used or accessed cash benefits in violation of OAR 461-165-0010(8)(a), the amount of the overpayment is the amount of cash benefits the client used or accessed.

(19) In the SFPSS and TANF programs, when an individual used or accessed cash benefits in violation of OAR 461-165-0010(9)(a), the amount of the overpayment is the amount of cash benefits the client used or accessed.

[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, HB 2089 (2013, Section 10)

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; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 36-2013(Temp), f. & cert. ef. 11-1-13 thru 4-30-14; SSP 9-2014, f. & cert. ef. 4-1-14; SSP 19-2015, f. & cert. ef. 7-1-15; SSP 2-2016, f. & cert. ef. 1-1-16; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

461-195-0541
Liability for Overpayments

(1) In all programs except the OCCS Medical, OSIP, OSIPM, QMB, REFM, 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 OCCS Medical and REFM programs, the following persons are liable for repayment of an overpayment:

(a) Each individual in the filing group, the OCCS Medical programs household group (see OAR 410-200-0015), 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 or OCCS Medical programs household group (see OAR 410-200-0015) when the overpayment was incurred.

(c) A parent or caretaker relative of a child in the filing group or OCCS Medical programs household group (see OAR 410-200-0015) 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 or OCCS Medical programs household group when the overpayment was incurred.

(d) An authorized representative (see OAR 461-001-0000 and OAR 410-200-0015) 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, 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.

(8) In the OCCS medical programs, the November 2013 amendments to OAR 461-195-0501, 461-195-0521, 461-195-0541, and 461-195-0561 apply as of October 1, 2013.

Stat. Auth.: ORS 409.050, 411.060, 411.404, 411.816, 412.014, 412.049, 2013 HB 2089 Sec. 10

Stats. Implemented: ORS 409.010, 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; SSP 23-2013, f. & cert. ef. 9-20-13; SSP 36-2013(Temp), f. & cert. ef. 11-1-13 thru 4-30-14; SSP 9-2014, f. & cert. ef. 4-1-14; SSP 25-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

Rule Caption: Adopting rules relating to Achieving a Better Life Experience (ABLE) accounts
Adm. Order No.: SSP 26-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Adopted: 461-145-0000
Subject: OAR 461-145-0000 about Achieving a Better Life Experience (ABLE) Act accounts is being adopted to comply with the Achieving a Better Life Experience (ABLE) Act of 2014 and SB 777 by excluding funds held in an ABLE Act account from eligibility determination for DHS assistance programs. Disbursements from such accounts are excluded as income so long as such payments are consistent with the definition of Qualified Disability Expenses (QDEs) as outlined in the ABLE Act and SB 777.
Rules Coordinator: Kris Skaro—(503) 945-6067

461-145-0000
Achieving a Better Life Experience (ABLE) Act

(1) For all programs, funds held in ABLE Act accounts are excluded as resources.

(2) For all programs, monies withdrawn from ABLE Act accounts are excluded as income if they are used for Qualified Disability Expenses. For purposes of this rule, "Qualified Disability Expenses" include, but are not limited to, the following:

(a) Education;
(b) Housing;
(c) Transportation;
(d) Employment training and support;
(e) Assistive technology and personal support services;
(f) Health;
(g) Prevention and wellness;
(h) Financial management and administrative services;
(i) Legal fees;
(j) Expenses for oversight and monitoring; and
(k) Funeral and burial expenses.

(3) For all programs, funds withdrawn from ABLE Act accounts for purposes other than those listed in section (2)(a) through (k) are counted as unearned income.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.049
Stats. Implemented: ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.049
Hist.: SSP 26-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Amending rule relating to ERDC child care provider requirements
Adm. Order No.: SSP 27-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16 thru 11-18-16
Notice Publication Date:
Rules Amended: 461-165-0180
Subject: OAR 461-165-0180 about child care provider eligibility requirements is being amended to state that to be eligible, a provider may not be the sibling living in the home of a child in the filing group per federal child care regulations. This change was adopted by temporary rule on May 23, 2016 but is being readopted to incorporate unrelated changes being permanently adopted. The rule text showing proposed changes is available at http://www.dhs.state.or.us/policy/selfsufficiency/ar_temporary.htm.
Rules Coordinator: Kris Skaro—(503) 945-6067

461-165-0180
Eligibility of Child Care Providers

(1) The Department must approve a child care provider to receive payment for child care if information available to the Department provides no basis for denying eligibility unless the Department determines, following a preliminary or final fitness determination (see OAR 407-007-0320) or Child Protective Service (CPS) records checks, that the provider or other subject individual (see OAR 407-007-0210(30)(a)(A), (B), (F), (I), and (P)) is not eligible for payment.

(2) Ineligibility for payment may result from any of the following:

(a) A finding of "denied".

(A) A provider may be denied under OAR 461-165-0410 and 461-165-0420. If, after conducting a weighing test as described in OAR 407-007-0210, the Department finds substantial risk to the health or safety of a child (see OAR 461-001-0000) in the care of the provider, the provider must be denied and is ineligible for payment.

(B) A provider who has been denied has the right to a hearing under OAR 407-007-0330.

(b) A finding of "failed".

(A) A provider may be failed if the Department determines, based on a specific eligibility requirement and evidence, that a provider does not meet an eligibility requirement of this rule not covered in paragraph (c)(A) of this section.

(B) While the provider is in failed status:

(i) The Department does not pay any other child care provider for child care at the failed provider's site.

(ii) The Department does not pay a child care provider at another site if the failed provider is involved in the child care operation unless the Department determines that the reasons the provider is in failed status are not relevant to the new site.

(C) A provider with a status of "failed" may reapply at any time by providing the required documents and information to the Department for review.

(c) A finding of "suspended".

(A) A provider may be suspended if the Department determines and provides notice that the provider does not meet an eligibility requirement in the following subsections and paragraphs of section (7) of this rule: (d), (e), (h), (i), (j), (k), (L), (o)(H), (o)(I), (o)(L), or (t) or in section (10) of this rule. A provider who has been suspended may challenge this status by requesting a contested case hearing subject to the requirements and limitations of OAR 461-025.

(B) While the provider is in suspended status:

(i) The provider is ineligible for payment for at least six months.

(ii) The Department does not pay any other child care provider for child care at the suspended provider's site.

(iii) The Department does not pay a child care provider at another site if the suspended provider is involved in the child care operation unless the Department determines that the reasons the provider is in suspended status are not relevant to the new site.

(C) A provider with a status of "suspended" may be eligible for payments after the six month ineligibility period ends when the provider has been approved following reapplication, including providing the required documents and information to the Department for review.

(d) The Department has referred an overpayment against the provider for collection and the claim is unsatisfied.

(3) The provider must submit a completed Child Care Provider Listing Form (DHS 7494) to the Department within 30 calendar days from the date the Department issues the listing form to the client. The provider and each individual identified under section (4) of this rule must complete and sign the authorization for a records check through the Criminal History (CH) record system maintained by the Oregon State Police (OSP), Federal Bureau of Investigation (FBI), and the Child Protective Service (CPS) record system maintained by the Department and, if necessary, an authorization to release information and fingerprint cards. The provider, each individual described in section (4) of this rule, and each subject individual described in OAR 407-007-0210(30)(a)(A), (B), (F), (I) or (P) must fully disclose all requested information as part of the records check.

(4) This rule also establishes additional requirements for the following individuals:

(a) The site director of an exempt child care facility and each employee of the facility who may have unsupervised access to a child in care.

(b) The child care provider and each individual the provider uses to supervise a child in his or her absence.

(c) In the case of a provider who provides care for a child in the provider's home:

(A) Each individual 16 years of age or older who lives in the provider's home; and

(B) Each individual who visits the home of the provider during the hours care is provided and may have unsupervised access to a child in care.

(5) To receive payment or authorization for payment, the provider must meet the requirements of either subsection (a) or (b) of this section:

(a) Currently be certified or registered with the Office of Child Care (OCC) of the Oregon Department of Education (ODE) under OAR 414-205-0000 to 414-205-0170, 414-300-0000 to 414-300-0440, or 414-350-0000 to 414-350-0250 unless legally exempt, and be in compliance with the applicable rules. The provider must also complete the Department's listing process and be approved by the Department.

(b) If legally exempt from being certified or registered with the OCC, complete the Department's background check process and be approved by the Department.

(6) Each individual described in section (4) of this rule must:

(a) Allow the Department to conduct a national criminal history records check through the Oregon State Police and the Federal Bureau of Investigation as specified in OAR 407-007-0250.

(b) Provide, in a manner specified by the Department, information required to conduct CH, FBI, OSP, and CPS records checks and determine whether the provider meets health and safety requirements.

(c) Have a history of behavior that indicates no substantial risk to the health or safety of a child in the care of the provider.

(7) Each provider must:

(a) Obtain written approval from their certifier or certifier's supervisor if the provider is also certified as a foster parent.

(b) Be 18 years of age or older and in such physical and mental health as will not affect adversely the ability to meet the needs of safety, health, and well-being of a child in care.

(c) Not be in the same filing group (see OAR 461-110-0350) as the child cared for; the parent (see OAR 461-001-0000) of a child in the filing group; or a sibling living in the home of a child in the filing group.

(d) Allow the Department to inspect the site of care while child care is provided.

(e) Keep daily attendance records showing the arrival and departure times for each child in care and billing records for each child receiving child care benefits from the Department. These written records must be retained for a minimum of 12 months and provided to the Department upon request.

(f) Be the individual or facility listed as providing the child care. The provider may only use someone else to supervise a child on a temporary basis if the person was included on the most current listing form and the provider notifies the Department's Direct Pay Unit.

(g) Not bill a Department client for an amount collected by the Department to recover an overpayment or an amount paid by the Department to a creditor of the provider because of a lien, garnishment, or other legal process.

(h) Report to the Department's Direct Pay Unit within five days of occurrence:

(A) Any arrest or conviction of any subject individual or individual described in section (4) of this rule.

(B) Any involvement of any subject individual or individual described in section (4) of this rule with CPS or any other agencies providing child or adult protective services.

(C) Any change to the provider's name or address including any location where care is provided.

(D) The addition of any subject individual or individual described in section (4) of this rule.

(E) Any reason the provider no longer meets the requirements under this rule.

(i) Report suspected child abuse of any child in his or her care to CPS or a law enforcement agency.

(j) Supervise each child in care at all times.

(k) Prevent any individual who behaves in a manner that may harm children from having access to a child in the care of the provider. This includes anyone under the influence (see section (11) of this rule).

(L) Allow the custodial parent of a child in his or her care to have immediate access to the child at all times.

(m) Inform a parent of the need to obtain immunizations for a child and have a completed, up-to-date Oregon shot record called the "Certification of Immunization Status" (CIS) form on file for each child in care.

(n) Take reasonable steps to protect a child in his or her care from the spread of infectious diseases.

(o) Ensure that the home or facility where care is provided meets all of the following standards:

(A) Each floor level used by a child has two usable exits to the outdoors (a sliding door or window that can be used to evacuate a child is considered a usable exit). If a second floor is used for child care, the provider must have a written plan for evacuating occupants in the event of an emergency.

(B) The home or facility has safe drinking water.

(C) The home or facility has a working smoke detector on each floor level and in any area where a child naps.

(D) Each fireplace, space heater, electrical outlet, wood stove, stairway, pool, pond, and any other hazard has a barrier to protect a child. Gates and enclosures have the Juvenile Products Manufacturers Association (JPMA) certification seal to ensure safety.

(E) Any firearm, ammunition, and other items that may be dangerous to children, including but not limited to alcohol, inhalants, tobacco and e-cigarette products, matches and lighters, any legally prescribed or over-the-counter medicine, cleaning supplies, paint, plastic bags, and poisonous and toxic materials are kept in a secure place out of a child's reach.

(F) The building, grounds, any toy, equipment, and furniture are maintained in a clean, sanitary, and hazard free condition.

(G) The home or facility has a telephone in operating condition.

(H) No one may smoke or carry any lighted smoking instrument, including e-cigarettes or vaporizers, in the home or facility or within ten feet of any entrance, exit, window that opens, or any ventilation intake that serves an enclosed area, during child care operational hours or anytime child care children are present. No one may use smokeless tobacco in the home or facility during child care operational hours or anytime child care children are present. No one may smoke or carry any lighted smoking instrument, including e-cigarettes and vaporizers, or use smokeless tobacco in motor vehicles while child care children are passengers.

(I) No one may consume alcohol or use controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) on the premises (see section (11) of this rule) during child care operational hours or anytime child care children are present. No one under the influence of alcohol, controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) may be on the premises during child care operational hours or anytime child care children are present. No one may consume alcohol or use controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) in motor vehicles while child care children are passengers.

(J) Is not a half-way house, hotel, motel, shelter, or other temporary housing such as a tent, trailer, or motor home. The restriction in this paragraph does not apply to licensed (registered or certified) care approved in a hotel, motel, or shelter.

(K) Is not a structure:

(i) Designed to be transportable; and

(ii) Not attached to the ground, another structure, or to any utilities system on the same premises.

(L) Controlled substances (except lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana, marijuana edibles, and other products containing marijuana), marijuana plants, derivatives, and associated paraphernalia may not be on the premises during child care operational hours or anytime child care children are present.

(p) Complete and submit a new listing form every two years, or sooner at the request of the Department, so that the Department may review the provider's eligibility.

(q) Provide evidence of compliance with the Department's administrative rules, upon request of Department staff.

(r) Comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety, and crib standards under 16 CFR 1219 and 1220.

(s) Place infants to sleep on their backs.

(t) Not hold a medical marijuana card; or distribute, grow, or use marijuana (including medical marijuana) or any controlled substance (except lawfully prescribed and over-the-counter medications).

(8) Child Care providers who are License Exempt or Registered Family Child Care Providers with the Office of Child Care (OCC) of the Oregon Department of Education (ODE) under OAR 414-205-0000 to 414-205-0170 must complete the "Basic Child Care Health and Safety" two-hour, web-based training or the three-hour Oregon Kids Healthy and Safe (OKHS) classroom training prior to being approved by the Department.

(a) Prior to June 16, 2014, a provider who sends the Department a Child Care Provider Listing and Provider Information Sheet (DHS 7494) with a revision date of March 2013, or those who attempt to take the web-based training but are unable due to technical difficulties at the training site, will not be failed for not meeting this training requirement.

(b) License Exempt or Registered Family Child Care Providers who are exempt from this training are those who state at least one of the following:

(A) English is a second language.

(B) No internet access is available.

(9) A child care provider not subject to certification or registration with the Office of Child Care (OCC) of the Oregon Department of Education (ODE) under OAR 414-205-0000 to 414-205-0170, 414-300-0000 to 414-300-0440, or 414-350-0000 to 414-350-0250, must complete

an orientation provided by the Department or a Child Care Resource and Referral agency within 90 days of being approved by the Department if he or she:

(a) Receives funds from the Department; and

(b) Begins providing child care services after June 30, 2010, or resumes providing child care services, after a break of more than one year that began after June 30, 2010.

(10) Child care providers and any individual supervising, transporting, preparing meals, or otherwise working in the proximity of child care children and those completing daily attendance and billing records shall not be under the influence.

(11) For purposes of these rules:

(a) "Premises" means the home or facility structure and grounds, including indoors and outdoors and space not directly used for child care.

(b) "Under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the individual has used alcohol, any controlled substances (including lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana), or inhalants that impairs their performance of essential job function or creates a direct threat to child care children or others. Examples of abnormal behaviors include, but are not limited to hallucinations, paranoia, or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech as well as difficulty walking or performing job activities.

Stat. Auth.: ORS 181.537, 329A.500, 409.050, 411.060, 411.070

Stats. Implemented: ORS 181.537, 329A.340, 329A.500, 409.010, 409.050, 409.610, 411.060, 411.070, 411.122

Hist.: 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 17-1994(Temp), f. & cert. ef. 8-15-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 2-1997, f. 2-27-97, cert. ef. 3-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 12-1997, f. & cert. ef. 8-25-97; AFS 14-1999, f. & cert. ef. 11-1-99; 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 12-2001, f. 6-29-01, cert. ef. 7-1-01; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 13-2004, f. 4-29-04, cert. ef. 5-1-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 6-2005(Temp), f. & cert. ef. 4-25-05 thru 9-30-05; 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 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 5-2014(Temp), f. 2-4-14, cert. ef. 3-1-14 thru 8-28-14; SSP 10-2014(Temp), f. & cert. ef. 4-1-14 thru 8-28-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 21-2014(Temp), f. & cert. ef. 8-13-14 thru 2-9-15; SSP 6-2015, f. 1-30-15, cert. ef. 2-1-15; SSP 17-2015, f. & cert. ef. 6-30-15; SSP 3-2016(Temp), f. & cert. ef. 1-20-16 thru 7-17-16; SSP 12-2016(Temp), f. & cert. ef. 3-14-16 thru 7-17-16; SSP 22-2016(Temp), f. & cert. ef. 5-23-16 thru 11-18-16; SSP 27-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 11-18-16

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Department of Justice
Chapter 137

Rule Caption: Implementing 2016 SB 1532 to incorporate changes to minimum wage.
Adm. Order No.: DOJ 8-2016
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 137-050-0715, 137-050-0750
Subject: OAR 137-050-0715 and 137-050-0750 are amended to address the changes in minimum wage from 2016 SB 1532.
Rules Coordinator: Carol Riches—(503) 378-5987

137-050-0715
Income

(1) "Income" means the actual or potential gross income of a parent as determined in this rule. Actual and potential income may be combined when a parent has actual income and is unemployed or employed at less than the parent's potential.

(2) "Actual income" means a parent's gross earnings and income from any source, including those sources listed in section (4), except as provided in section (5).

(3) "Potential income" means the parent's ability to earn based on relevant work history, including hours typically worked by or available to the parent, occupational qualifications, education, physical and mental health, employment potential in light of prevailing job opportunities and earnings levels in the community, and any other relevant factors. A determination of potential income includes potential income from any source described in section 4 of this rule. If a parent residing in Oregon is determined to be able to earn at the minimum wage, the hourly earning amount to be imputed as potential income will be based on the lowest minimum wage provided for in any area of Oregon.

(4) Actual income includes but is not limited to:

(a) Employment-related income including salaries, wages, commissions, advances, bonuses, dividends, recurring overtime pay, severance pay, pensions, and honoraria;

(b) Expense reimbursements, allowances, or in-kind payments to a parent, to the extent they reduce personal living expenses;

(c) Annuities, trust income, including distribution of trust assets, and return on capital, such as interest and dividends;

(d) Income replacement benefit payments including Social Security benefits, workers' compensation benefits, unemployment insurance benefits, disability insurance benefits, and Department of Veterans Affairs disability benefits;

(e) Inheritances, gifts and prizes, including lottery winnings; and

(f) Income from self-employment, rent, royalties, proprietorship of a business, or joint ownership of a partnership or closely held corporation, minus costs of goods sold, minus ordinary and necessary expenses required for self-employment or business operation, including one-half of the parent's self-employment tax, if applicable. Specifically excluded from ordinary and necessary expenses are amounts allowable by the Internal Revenue Service for the accelerated component of depreciation expenses, investment tax credits, or any other business expenses determined by the fact finder to be inappropriate or excessive for determining gross income.

(5) Child support, food stamps, Social Security or Veterans benefits received on behalf of a child in the household, adoption assistance, guardianship assistance, and foster care subsidies are not considered income for purposes of this calculation.

(6) If a parent's actual income is less than the parent's potential income, the court, administrator, or administrative law judge may impute potential income to the parent.

(7) If insufficient information about the parent's income history is available to make a determination of actual or potential income, the parent's income is the amount the parent could earn working full-time at the lowest minimum wage in the state in which the parent resides.

(8) Potential income may not be imputed to:

(a) A parent unable to work full-time due to a verified disability;

(b) A parent receiving workers' compensation benefits;

(c) An incarcerated obligor as defined in OAR 137-055-3300; or

(d) A parent whose order is being temporarily modified under ORS 416.425(13).

(9) To determine monthly income when the employee is paid:

(a) Weekly, multiply the weekly earnings by 52 and divide by 12.

(b) Every two weeks, multiply the bi-weekly earnings by 26 and divide by 12.

(c) Semimonthly (twice per month), multiply the semimonthly earnings by 2.

(10) Notwithstanding any other provision of this rule, if the parent receives Temporary Assistance for Needy Families, the parent's income is presumed to be the amount which could be earned by full-time work at the lowest minimum wage in the state in which the parent resides. This income presumption is solely for the purposes of the support calculation and not to overcome the rebuttable presumption of inability to pay in ORS 25.245.

(11) As used in this rule, "full-time" means 40 hours of work in a week except in those industries, trades or professions in which most employers, due to custom, practice or agreement, utilize a normal work week of more or less than 40 hours in a week.

Stat. Auth.: ORS 25.270 - 25.290 & 180.345

Stats. Implemented: ORS 25.270 - 25.290

Hist.: DOJ 16-2009, f. 12-1-09, cert. ef. 1-4-10; DOJ 6-2010(Temp), f. & cert. ef. 2-12-10 thru 7-1-10; DOJ 11-2010, f. & cert. ef. 7-1-10; DOJ 3-2013, f. 5-15-13, cert. ef. 7-1-13; DOJ 8-2016, f. & cert. ef. 7-1-16

137-050-0750
Medical Support

(1) The basic support obligation (OAR 137-050-0725) includes ordinary unreimbursed medical costs of $250 per child per year. These costs represent everyday expenses such as bandages, non-prescription medication, and co-pays for doctor's well visits. The basic support obligation does not account for health care coverage costs or for extraordinary medical expenses.

(2) "Cash medical support", as used in OAR 137-050-0700 through 137-050-0765, has the meaning given in ORS 25.321(1).

(3) For purposes of this rule, "to provide" health care coverage means to apply to enroll the child and pay any costs associated with the enrollment, even if the cost to the parent is zero.

(4) For purposes of ORS 25.323, private health care coverage may be "available" to a parent from any source, including but not limited to an employer, spouse, or domestic partner.

(5) Private health care coverage is reasonable in cost if it costs no more than the total of four percent of each parent's adjusted income as determined in OAR 137-050-0720.

(a) The amount calculated for each parent in this section may not exceed that parent's available income after deducting the parent's shares of basic support obligation and child care costs.

(b) The reasonable cost contribution of a parent whose income is at or below the highest Oregon minimum wage for full-time employment is zero.

(6) A parent with income at or below the highest Oregon minimum wage for full-time employment may be ordered to provide health care coverage only if it is available at no cost.

(7) Compelling factors may support a finding that health care coverage is reasonable in cost at an amount greater than the amount determined in section 5 of this rule so long as the providing parent has income greater than full-time employment at the highest Oregon minimum wage.

(8) In determining the cost of private health care coverage, consider only the cost to the parents of covering the children for whom support is sought. To calculate the amount to be considered:

(a) If there is a known cost for self-only coverage for the providing parent, deduct that cost from the cost of family coverage. Divide the remainder by the total number of people covered, excluding the providing parent. Multiply the result by the number of children for whom coverage is sought in the present calculation.

(b) If there is no self-only coverage option or the cost cannot be determined, divide the total cost of coverage by total number of people covered, including the providing parent. Multiply the result by the number of children for whom coverage is sought in the present calculation.

(9) If only one parent has private health care coverage that is appropriate and available under ORS 25.323, that parent must be ordered to provide it.

(10) If both parents have access to appropriate, available private health care coverage, the parent with the greater share of parenting time as determined in OAR 137-050-0730 (Parenting Time Credit) may select which coverage will be ordered.

(a) If the parent with the greater share of parenting time does not select between the parents' coverage, or each parent has exactly 50% or 182.5 overnights of parenting time and the parents do not agree on which policy should be ordered, the policy with the lower out-of-pocket premium cost will be ordered unless the court, administrator, or administrative law judge makes a finding that the more expensive policy should be ordered.

(b) The parents may agree that both parents will be ordered to provide private coverage if both parents have appropriate coverage available so long as the total coverage to be provided is reasonable in cost under sections 5 or 7 of this rule.

(11) If the child lives with a caretaker, both parents are parties to the action, and both parents have appropriate and available private health care coverage, the caretaker may select which coverage will be ordered. If the caretaker does not select between the parents' coverage, the policy with the lower out-of-pocket premium cost will be ordered unless the court, administrator, or administrative law judge makes a finding that the more expensive policy should be ordered.

(12) If neither parent has access to appropriate, available private health care coverage:

(a) One or both parents must be ordered to provide appropriate private health care coverage at any time whenever it becomes available;

(b) The parent with custody of the child may be ordered to provide public health care coverage for the child; and

(c) Either or both parents who are found to have a cash child support obligation as provided in OAR 137-050-0710(1)(i) must be ordered to pay cash medical support, or the order must include a finding explaining why cash medical support is not ordered. The amount of the cash medical support obligation is the lesser of:

(A) four percent of the parent's adjusted income as determined in OAR 137-050-0720,

(B) the parent's available income after deducting the parent's shares of basic support obligation and child care costs, or

(C) zero, if the parent's income is at or below the highest Oregon minimum wage for full-time employment.

(13) A medical support clause may order an obligor to provide appropriate private health care coverage whenever it is available to the obligor, and to pay cash medical support whenever the obligor does not provide appropriate private health care coverage.

(14) Determine each parent's share of the cost of health care coverage to be ordered under this rule by multiplying the total cost by each parent's percentage share of the parents' combined reasonable in cost limitation, as determined in section 5 of this rule.

(a) If only one parent has income above the highest Oregon minimum wage, that parent is responsible for all health care coverage costs. No share of the cost is apportioned to a parent with income at or below the highest Oregon minimum wage as provided in section 12(c)(C) of this rule.

(15) When enforcing the health insurance provision of a child support judgment entered under this rule, health insurance is reasonable in cost if the premium cost for the child is equal to or less than the amount that was determined reasonable in cost under section 5 of this rule based on both parents' income at the time support was calculated, regardless of whether that cost exceeds either:

(a) The providing parent's individual contribution to the reasonable cost cap, or

(b) The actual cost of insurance allocated to the providing parent under section 14 of this rule.

Stat. Auth.: ORS 25.270 – 25.290, 25.323 & 180.345
Stats. Implemented: ORS 25.270 – 25.290 & 25.321 – 25.343
Hist.: DOJ 16-2009, f. 12-1-09, cert. ef. 1-4-10; DOJ 12-2011, f. 12-30-11, cert. ef. 1-3-12; DOJ 3-2013, f. 5-15-13, cert. ef. 7-1-13; DOJ 8-2016, f. & cert. ef. 7-1-16

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Department of Public Safety Standards and Training Chapter 259

Rule Caption: Amends rule language revising the definition of "Organized Event" and adding the definition of "Premises".
Adm. Order No.: DPSST 7-2016
Filed with Sec. of State: 6-22-2016
Certified to be Effective: 6-22-16
Notice Publication Date: 6-1-2016
Rules Amended: 259-060-0010
Subject: DPSST filed a temporary rule during the 2015 summer event season and a permanent rule in December 2015 to help alleviate confusion regarding the crowd management exemption from private security provider responsibilities. This rule change amends the definition of "Organized Event" and adds the definition for "Premises" to provide additional clarification regarding private security provider responsibilities and the crowd management exemption.
Rules Coordinator: Jennifer Howald—(503) 378-2432

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) "Assessments" 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 181A.855 and these rules.

(9) "Confrontational Activity" means the exertion of physical control by detaining individuals.

(10) "Consideration" means something of value promised, given or done that has the effect of making an agreement to provide private security services.

(11) "Crowd Management or Guest Services" means duties performed during an organized event, including pre-event assembly and post-event departure activities relating to the organized event that involve:

(a) Directing people attending an organized event;

(b) Allowing entry into or exit out of an organized event or any area within the established confines of an organized event that requires authorized access; or

(c) Screening individuals for entry into an organized event. Screening does not include physical pat-down searches.

(12) "De Minimis" means non-monetary compensation received by a volunteer performing private security services for a non-profit organization as defined in ORS 181A.845. The compensation may not exceed a fair market value of $125 per day.

(13) "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.

(14) "Department" and "DPSST" means the Department of Public Safety Standards and Training.

(15) "Director" means the Director of the Department of Public Safety Standards and Training.

(16) "Employer" means:

(a) An individual who employs persons to provide private security services;

(b) An owner or owners of a business or entity that provides private security services; or

(c) An owner or owners of a business or entity who employs persons to provide private security services.

(17) "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 181A.840 to 181A.995.

(18) "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.

(19) "Fundamental" means a duty that is a basic task or function and may be low frequency, but is an essential component of a job.

(20) "Incidental or Temporary Action" means reaction to an unexpected occurrence that requires immediate response and occurs without regularity or expectation. These actions are not primary responsibilities and are for brief periods of time.

(21) "Instructor" means any person who has been certified by the Department as meeting the requirements to provide instruction to private security providers or applicants.

(22) "License" means recognition by the Department that executive manager or supervisory manager meets the requirements listed in ORS 181A.855 and these rules.

(23) "Organized Event" means a temporary gathering of a crowd for a planned occasion or activity that occurs in a defined location during a specific time. An organized event has an established border or boundary.

(24) "Policy Committee" means the Private Security and Investigator Policy Committee.

(25) "Premises" means:

(a) Land or buildings considered as a property, regardless if permanent or temporary; or

(b) With respect to a licensee of the Oregon Liquor Control Commission (OLCC), a permanent place where an OLCC license is held regularly or a location where licensees can gather for a temporary amount of time.

(26) "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.

(27) "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.

(28) "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. A private security professional is not authorized to independently contract with businesses or entities to provide services as a private security professional.

(29) "Private Security Provider" means any individual who performs the functions of a private security professional, executive manager, supervisory manager or instructor.

(30) "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.

(31) "Private Security Services Providers Act" or "The Act" means the Private Security Providers Act (ORS Chapter 181A.840 through 181A.995).

(32) "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.

(33) "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. A supervisory manager is not authorized to independently contract with businesses or entities to provide services as a supervisory manager.

(34) "Surrender" means the voluntary relinquishment of private security certification or licensure to the Department.

(35) "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.

(36) "Temporary Work Permit" means a temporary certification or licensure issued by an employing, licensed manager 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.

(37) "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.

(38) "Violation" means an act or omission that is prohibited under the Act or these rules.

(39) "Withdraw" means action taken by the applicant or private security provider to remove an application from consideration.

Stat. Auth.: ORS 181A.840 & 181A.870

Stats. Implemented: ORS 181A.840 & 181A.870

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; DPSST 3-2015, f & cert. ef. 1-5-15; DPSST 8-2015, f. & cert. ef. 3-24-15; DPSST 9-2015(Temp), f. & cert. ef. 5-19-15 thru 11-14-15; Administrative cor-

rection, 11-20-15; DPSST 20-2015, f. & cert. ef. 12-22-15; DPSST 7-2016, f. & cert. ef. 6-22-16

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Rule Caption: Private security provider responsibilities for temporary work permits and application for certification/licensure regarding copies/electronic submission.
Adm. Order No.: DPSST 8-2016
Filed with Sec. of State: 6-22-2016
Certified to be Effective: 6-22-16
Notice Publication Date: 6-1-2016
Rules Amended: 259-060-0015, 259-060-0025, 259-060-0030
Subject: This rule change adds the requirement that private security providers present their certification or licensure upon request to OAR 259-060-0015. This rule change allows the Department to accept copies, faxes, or emailed PDF's of the Form PS-20 and the Form PS-9. The rule language has been amended to allow for electronic submission of the Form PS-20 and the Form PS-9 by fax or by email. Language has also been added to address replacing a temporary work permit, as well as housekeeping for consistency throughout the rule set.
Rules Coordinator: Jennifer Howald—(503) 378-2432

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) Private security providers must have in their possession their DPSST issued certification, licensure or temporary work permit (Form PS-20) while performing the functions of a private security provider and must be able to present their license, certificate, or temporary work permit to any DPSST staff member, law enforcement officer or Oregon Liquor Control Commission agent upon demand, or any other person, upon reasonable request.

(3) Persons described in ORS 181A.845 are exempt from regulation as private security providers.

(a) The exemption found in ORS 181A.845(1)(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.

(b) The exemption found in ORS 181A.845(1)(k) applies to individuals performing crowd management or guest services inside the established confines of an organized event and who are not armed, permitted to initiate confrontational activities, or hired with the primary responsibility of taking enforcement action as described in ORS 181A.840(8)(f).

(4) Private security providers are prohibited from:

(a) Carrying a concealed weapon while providing security services unless currently certified as an armed private security professional and licensed under ORS 166.291; and

(b) Providing training to private security professionals or applicants unless currently certified as an instructor.

(5) 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.

(6) 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.

(7) Notification of Arrest. Pursuant to ORS 181A.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.

(8) 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 181A.870
Stats. Implemented: ORS 181A.870
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; DPSST 9-2015(Temp), f. & cert. ef. 5-19-15 thru 11-14-15; Administrative correction, 11-20-15; DPSST 20-2015, f. & cert. ef. 12-22-15; DPSST 8-2016, f. & cert. ef. 6-22-16

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, a 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), including proof of at least eight hours of continuing education taken within the last certification period. Proof can be in the form of a grade or certificate, minutes, a roster, or receipt of course payment;

(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, a 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 professional applying to add armed private security certification must have in their possession a copy of the Form PS-6 and the Form PS-23 (Change of Information) while performing the duties of an armed private security professional 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 professional applying to upgrade to armed private security certification must have in their possession a copy of the Form PS-6 and the Form PS-23 (Change of Information) while performing the duties of an armed private security professional until a new certificate is received.

(3) Timelines.

(a) A completed application packet must be submitted electronically or mailed and postmarked to the Department 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; DPSST 26-2014, f. & cert. ef. 10-1-14; DPSST 8-2016, f. & cert. ef. 6-22-16

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).

(A) One copy of the Form PS-20 must be submitted electronically or mailed and postmarked to the Department on or before the first day the applicant performs private security services.

(B) Additional copies of the Form PS-20 must be retained by the employer and employee.

(C) The employee must have a copy of their Form PS-20 in their possession while performing the functions of a private security provider and must be able to present their copy of the PS-20 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 without Department approval. The issued and expiration dates on a replacement Temporary Work Permit must be the same dates listed on the lost or destroyed Temporary Work Permit.

(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 181A.850(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.)

(A) One copy of the Form PS-9 must be submitted electronically or mailed and postmarked to the Department on or before the first day the applicant performs private security services.

(B) Additional copies of the Form PS-9 must be retained by the employer and employee.

(C) The employee must have a copy of their Form PS-9 in their possession while performing the functions of a private security provider and must be able to present their copy of the PS-9 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; DPSST 8-2016, f. & cert. ef. 6-22-16

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Rule Caption: Amends rule regarding private security executive/supervisory manager licensure/responsibilities to reflect current basic training requirements.
Adm. Order No.: DPSST 9-2016
Filed with Sec. of State: 6-22-2016
Certified to be Effective: 6-22-16
Notice Publication Date: 6-1-2016
Rules Amended: 259-060-0130
Subject: This rule change amends the language to reflect the current basic training requirements as a prerequisite for obtaining a manager's license. On March 24, 2015, DPSST filed a permanent rule change that updated the minimum number of hours required for the basic training course for initial certification as an unarmed private security professional from 12 hours (eight hours of classroom and four hours of assessments) to 14 hours total. Language in OAR 259-060-0130 (Private Security Executive and Supervisory Manager Licensure and Responsibilities) was not updated during the 2015 basic training rule filing.
Rules Coordinator: Jennifer Howald—(503) 378-2432

259-060-0130
Private Security Executive Manager and Supervisory Manager Licensure and Responsibilities

(1) All private security executive or supervisory manager applicants must complete an application in accordance with OAR 259-060-0025.

(2) All private security executive or supervisory manager applicants must be in compliance with the minimum standards for licensure as listed in OAR 259-060-0020.

(3) Private security executive managers are responsible for ensuring compliance of all private security providers employed by businesses or entities by which the executive manager is employed or contracted. An executive manager is authorized to perform the duties defined in OAR 259-060-0010.

(4) Private security supervisory managers have the responsibility and authority of supervising persons providing security services. A supervisory manager is authorized to perform the duties defined in OAR 259-060-0010.

(5) Basic training for executive and supervisory private security managers consists of successful completion of the following:

(a) The required basic classroom instruction, exam and assessments as defined in OAR 259-060-0120; and

(b) Manager course, exam and assessments.

(6) Biennial renewal training consists of the manager course, exam and assessments.

(7) Each business, employer or entity with private security professional staff of at least one person must designate an individual to perform the duties of an executive manager as described in these rules. This provision applies 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 or out of this state.

(a) An employer may obtain licensure for more than one executive manager.

(b) In the event of a staff change of executive managers or supervisory managers, the business, employer or entity must select a replacement manager and immediately notify the Department of the staff change on the Form PS-23 (Change of Information.)

(8) Employing, licensed managers may issue temporary work permits to private security applicants upon verification that all application requirements have been completed.

(9) An executive manager is authorized to contract with businesses or entities to provide services as an executive manager.

(a) An executive manager is required to notify the Department in writing of the names, addresses and contact information of each business or entity with which they contract within two days of beginning the contract.

(b) An executive manager must notify the Department within two days of the termination or completion of a contract with a business or entity.

(c) For the purposes of this rule, an executive manager who contracts with businesses or entities to provide services as an executive manager is considered an employing, licensed manager.

(10) A licensed manager who performs private security services must complete the full training required for that classification and be certified.

(11) 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 181.878

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 6-2008, f. & cert. ef. 4-15-08; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 3-2015, f & cert. ef. 1-5-15; DPSST 8-2015, f. & cert. ef. 3-24-15; DPSST 9-2016, f. & cert. ef. 6-22-16

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Department of Revenue
Chapter 150

Rule Caption: Cash handling: Establishes rule for remitting cash payments to the Oregon Department of Revenue
Adm. Order No.: REV 3-2016
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Adopted: 150-305.100-(E)
Subject: 150-305.100-(E) — Provides guidance and procedures to remit cash payments for any taxes, fees, or debts administered by the Oregon Department of Revenue (DOR). DOR district field offices will only accept cash payments up to $500 for any purpose, no more than five (5) cash payments per month, July 1, 2016 to December 31, 2016. Eliminates acceptance of cash payments at DOR field offices after December 31, 2016.
Rules Coordinator: Lois Williams—(503) 945-8029

150-305.100-(E)
Acceptance of Cash Payments

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

(a) "Currency" means United States coin and paper notes issued by the United States Federal Reserve Banks that are not mutilated as described in 31 CFR 100.5, 100.11, and 100.12 or contaminated such that they cannot be safely processed under routine operating procedures.

(b) "Faced" means United States paper currency presented facing portrait-side up.

(c) "Oriented" means United States paper currency presented so that the words on the bill are right-side up from the perspective of the reader.

(d) "Department district office" includes all Oregon Department of Revenue offices, but does not include certain designated department satellite offices or the department's main building at 955 Center Street NE, Salem, Oregon 97301.

(2) All payments made to the department in currency must follow the cash handling requirements set forth in this rule. This rule is adopted consistent with the Oregon Treasury Department's Policy FIN 201: Collection and Deposit of Money(s).

(3) Sections (4) and (5) of this rule are effective July 1, 2016 through December 31, 2016.

(4) A payor may not make more than one deposit or payment of currency in a department district office per day. A deposit or payment of currency made by a payor in a department district office may not exceed $500.

(5) A payor may make no more than five deposits or payments of currency in a department district office during a calendar month.

(6) On or after January 1, 2017, all deposits or payments of currency must be delivered to the department's main building at 955 Center Street, NE, Salem, Oregon 97301. No deposits or payments of currency will be accepted at any other location. Deposits or payments of currency may not be remitted to the department via the United States Postal Service or any other mail courier.

(7) The department may determine and publish a threshold amount for delivery of deposits or payments of currency without an appointment. If the deposit or payment of currency exceeds the threshold amount, the department may require payors to schedule an appointment to deliver a deposit or payment of currency. The threshold amount may be found in forms, instructions, or other forms of media provided by the department.

(8) The department will accept no more than one dollar in United States coins as part of each deposit or payment of currency.

(9) If a payor must schedule an appointment to deliver deposits or payments of currency to the department, the deposits or payments of currency must be sorted by denomination, faced and oriented upon delivery.

(10) The department will not accept any mutilated or contaminated currency.

(11) All deposits or payments of currency that require an appointment must be accompanied by a completed payment voucher that shows the amount of tax or other debt being paid with currency.

(12) The department will provide a receipt for deposits or payments made in person at the Oregon Department of Revenue. The receipt will identify the amount paid, the tax period or other applicable account information to which the deposit or payment will be applied, the name of the payor, the business identification number or social security number, and the date the deposit or payment was paid to the department.

(13) If the department calculates an amount of a deposit or payment of currency that does not match the amount asserted by a payor as having been paid and the payor is not able to provide a department-issued receipt for that deposit or payment, the department will credit to the payor's account the amount as determined by the department.

[Publications: Contact the Oregon Department of Revenue for information about how to obtain a copy of the publication referred to or incorporated by reference in this rule pursuant to ORS 183.360(2) and 183.355(1)(b).]
Stat. Auth.: ORS 305.100
Stats. Implemented: ORS 305.100
Hist.: REV 3-2016, f. & cert. ef. 7-1-16

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Rule Caption: Marijuana Tax: Establishes rules for permanent point-of-sale taxation of marijuana items.
Adm. Order No.: REV 4-2016
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Adopted: 150-475B.710-(A), 150-475B.710-(B), 150-475B.710-(C), 150-475B.715, 150-475B.720, 150-475B.740, 150-475B.755
Subject: 150-475B.710-(A) — Establishes deposit due dates for remitting marijuana point-of-sale taxes to the Oregon Department of Revenue.

150-475B.710-(B) — Provides guidance for marijuana retailers to request an extension to file a quarterly marijuana tax return and clarifies definition of "good cause" used to consider filing extension requests.

150-475B.710-(C) — Requires marijuana retailers to register with the Oregon Department of Revenue to report and remit marijuana point-of-sale taxes.

150-475B.715 — Clarifies provisions in statute for assessing delinquent marijuana tax against a marijuana retailer or medical marijuana dispensary and any liable officer, member, or employee of a marijuana retailer or medical marijuana dispensary per statutory authorities. Establishes criteria the department will consider to assess liability against any responsible officer, member, or employee of a marijuana retailer or medical marijuana dispensary for delinquent marijuana tax.

150-475B.720 — Clarifies provisions in statute for providing guidance for acceptable recordkeeping formats and maintenance of books, papers, accounts, or other information related to marijuana tax and the authority of the department to request books, papers, accounts or other information for audit purposes.

150-475B.740 — Clarifies provisions in statute for consumer requests for refund of excess marijuana tax paid at the point-of-sale.

150-475B.755 — Clarifies provisions in statute for assessing a 100 percent penalty for a failure to file a marijuana tax return for three consecutive years.
Rules Coordinator: Lois Williams—(503) 945-8029

150-475B.710-(A)
Marijuana Tax: Due Dates

(1) For purposes of OAR 150-475B.710 to 150-475B.755, "marijuana retailer" has the meanings given under ORS 475B.015 and includes:

(a) A registered medical marijuana dispensary that elects to sell limited marijuana retail products, as defined under section 2, chapter 784, Oregon Laws 2015, from January 4, 2016 through December 31, 2016; or

(b) A marijuana retailer licensed by the Oregon Liquor Control Commission who sells marijuana items on or after January 4, 2016.

(2) A marijuana retailer that sells marijuana items, as defined in ORS 475B.015, must pay all marijuana taxes due for each tax period by the due dates described in ORS 475B.710 and this rule. When the due date falls on a Saturday, Sunday or a state legal holiday, the deposit or payment is due on the next business day following such Saturday, Sunday or state legal holiday.

(3) A marijuana retailer must pay the marijuana tax due in three monthly deposits for each calendar quarter. The first monthly deposit is due on or before the last day of the second month of the calendar quarter; the second monthly deposit is due on or before the last day of the third month of the calendar quarter; and the third monthly deposit is due on or before the last day of the month following the close of the calendar quarter.

(4) If a marijuana retailer does not make any sales of marijuana items in a particular month of a calendar quarter, the marijuana retailer is not required to remit payment of marijuana tax for that month.

(5) The marijuana retailer may retain two percent of the amount of tax collected on sales of marijuana items as provided under ORS 475B.745.

(6) A marijuana tax deposit for each month in a tax period, as established in subsection (3) of this rule, consists of the total amount of retail sales of marijuana items for that month multiplied by the associated tax rates as defined in ORS 475B.705 less two percent referenced in section (5) of this rule.

Example: It's Easy Being Green, LLC is a marijuana retailer licensed by the Oregon Liquor Control Commission and has $300,000 in April sales resulting in tax liability of $49,980 (($300,000 x .17) x .98) and the deposit of the tax is due on or before May 31. The marijuana retailer's sales of $250,000 in May result in tax liability of $41,650 (($250,000 x .17) x .98) that is due on or before June 30. And the marijuana retailer's sales of $325,000 in June result in tax liability of $54,145 (($325,000 x .17) x .98) that is due on or before July 31. All tax calculations in this example exclude two percent of the taxes collected for administrative expenses as allowed by statute.
Stat. Auth.: ORS 305.100, ORS 475B.750
Stats. Implemented: ORS 475B.710
Hist.: REV 2-2015(Temp), f. 12-8-15, cert. ef. 1-4-16 thru 7-1-16; REV 4-2016, f. & cert. ef. 7-1-16

150-475B.710-(B)
Filing Extension for Marijuana Tax Return

(1) For purposes of this rule, "good cause" means circumstances beyond the control of the marijuana retailer as established under section (5)(a) of OAR 150-305.145(4).

(2) For purposes of this rule, "good cause" does not include:

(a) Circumstances established in section (5)(b) of OAR 150-305.145(4);

(b) Lack of knowledge about filing deadlines or requirements;

(c) Other circumstances that are within the control of the marijuana retailer or its representatives.

(3) If, for good cause, a marijuana retailer is unable to file a marijuana tax return within the statutorily prescribed time, the department may grant the marijuana retailer an extension of time for filing the return. The extension for filing a return does not extend the time for payment of the marijuana tax.

(4) A marijuana retailer may request a 30-day extension to file a return of marijuana tax by submitting a written request for extension to the department. The marijuana retailer must file the extension request and remit the marijuana tax on or before the due date for the tax period for which the extension is requested. The department's decision whether to grant an extension request for good cause will be based upon the facts and circumstances in each case.

(5) Each written request for an extension to file a marijuana tax return must contain the name of the marijuana retailer, the marijuana retailer's business identification number, the tax period associated with the request, and an explanation of the reason for requesting additional time to file the return.

(6) If the extension to file a marijuana tax return is granted, the marijuana retailer must file the return within 30 days of the original due date of the return.

(7) The department may require documentary proof to substantiate assertions of good cause when making a determination whether an extension to file a return is warranted.

Stat. Auth.: ORS 305.100, 475B.750
Stats. Implemented: ORS 475B.710
Hist.: REV 2-2015(Temp), f. 12-8-15, cert. ef. 1-4-16 thru 7-1-16; REV 4-2016, f. & cert. ef. 7-1-16

150-475B.710-(C)
Marijuana Tax: Registration of Marijuana Retailers

(1) A marijuana retailer must register with the department as a marijuana tax collector. The department will assign a business identification number to each marijuana retailer. A marijuana retailer must use the business identification number on all reports and payment vouchers filed with the department that are associated with the marijuana tax. A business identification number is required to schedule an appointment to make marijuana tax cash deposits or payments with the department.

(2) The department will make forms available for reports and payment vouchers for use by marijuana retailers in reporting and paying marijuana tax.

(3) A marijuana retailer must notify the department in writing if the status of the marijuana retailer changes including, but not limited to, ownership changes, address changes, or the marijuana retailer no longer sells limited marijuana retail products or marijuana items.

[Publications: Contact the Oregon Department of Revenue to obtain a copy of the publication referred to or incorporated by reference in this rule pursuant to ORS 183.360(2) and 183.355(1)(b).]

Stat. Auth.: ORS 305.100, 475B.750
Stats. Implemented: ORS 475B.710
Hist.: REV 2-2015(Temp), f. 12-8-15, cert. ef. 1-4-16 thru 7-1-16; REV 4-2016, f. & cert. ef. 7-1-16

150-475B.715
Liability for Unpaid Marijuana Tax; Warrant for Collection

(1) For purposes of this rule, "marijuana retailer" has the meaning given under OAR 150-475B.710-(A) and includes, but is not limited to, an officer, member or employee of a corporation, partnership or other business entity that makes retail sales of marijuana items to consumers, if, among other duties, that individual has:

(a) The power or authority to see that the marijuana taxes are paid when due;

(b) Authority to prefer one creditor over another;

(c) Authority to hire and dismiss employees;

(d) Authority to set employees' working conditions and schedules;

(e) Authority to sign or co-sign checks;

(f) Authority to compute and sign marijuana tax reports;

(g) Authority to make fiscal decisions for the business; or

(h) Authority to incur debt on behalf of the business.

(2) It is the duty of a marijuana retailer to hold in trust any amount of marijuana tax collected from the sale of limited retail marijuana products or marijuana items and to assume custodial liability for amounts to be paid to the department. Any marijuana retailer who fails to pay the marijuana tax when due is subject to penalties as provided by law as any other taxpayer who fails to file a return or pay a tax when due. Any marijuana retailer who fails to pay any marijuana tax when due to the department violates ORS 314.075 and is subject to the penalty provisions of ORS 314.991(1).

(3) If a marijuana retailer fails to file returns or to pay any collected marijuana tax when due, any or all officers, members, and employees may be held personally responsible, as provided in this rule, for the returns and payments together with any interest and penalties due.

(4) If the department issues a Notice of Liability or Notice of Determination and Assessment naming any officer, member, or employee as liable for unpaid marijuana tax, the department may issue a warrant against the individual to enforce collection of any amount of delinquent marijuana tax, including penalties and interest.

(5) To be held personally liable for unpaid marijuana tax under ORS 475B.715, a person must be a marijuana retailer. In addition, the person must be in a position to pay the marijuana tax or direct the payment of the marijuana tax at the time the duty arises to collect or pay over the marijuana taxes. The person may be personally liable if the individual was, or should have been aware, that the marijuana taxes were not paid to the department. A marijuana retailer cannot avoid personal liability by delegating their responsibilities to another.

(6) The following factors do not preclude a finding that an individual is liable for the payment of marijuana taxes:

(a) Lack of willfulness in failing to pay over the required marijuana tax;

(b) The individual's receipt of remuneration;

(c) Maintenance of full-time employment elsewhere;

(d) Another individual is also liable for the same marijuana taxes;

(e) A corporate bylaw or partnership agreement position description to the contrary;

(f) Absence of signatory authority on a business bank account;

(g) Absence of bookkeeping or recordkeeping duties;

(h) Absence of authority to hire, fire, and to set working conditions and schedules; or

(i) Delegation to another person any functions indicating liability.

Stat. Auth.: ORS 305.100, 475B.750
Stats. Implemented: ORS 475B.755
Hist.: REV 4-2016, f. & cert. ef. 7-1-16

150-475B.720
Model Recordkeeping and Retention Regulation (Marijuana Tax)

(1) Definitions. For purposes of this rule, these terms shall be defined as follows:

(a) "Database Management System" means a software system that controls, relates, retrieves, and provides accessibility to data stored in a database.

(b) "Electronic Data Interchange" or "EDI technology" means the computer-to-computer exchange of business transactions in a standardized structured electronic format.

(c) "Hard copy" means any documents, records, reports or other data printed on paper.

(d) "Machine-sensible record" means a collection of related information in an electronic format. Machine-sensible records do not include hard-copy records that are created or recorded on paper or stored in or by an imaging system such as microfilm, microfiche, or storage-only imaging systems.

(e) "Storage-only imaging system" means a system of computer hardware and software that provides for the storage, retention and retrieval of documents originally created on paper. It does not include any system, or part of a system, that manipulates or processes any information or data contained on the document in any manner other than to reproduce the document in hard copy or as an optical image.

(f) "Marijuana retailer" has the meanings given under ORS 475B.015 and OAR 150-475B.710-(A).

(2) Recordkeeping Requirement — General:

(a) A marijuana retailer shall maintain all records and any inventory tracking activities information and data required to be entered into the Oregon Liquor Control Commission's Cannabis Tracking System that are necessary to a determination of the correct tax liability under ORS 475B.700 to 475B.760. All required records shall be made available on request by the Department of Revenue or its authorized representatives as provided for in ORS 475B.720 and 475B.725.

(b) If a marijuana retailer retains records required to be retained under this rule in both machine-sensible and hard-copy formats, the marijuana retailer shall make the records available to the department in machine-sensible format upon request of the department.

(c) Nothing in this rule shall be construed to prohibit a marijuana retailer from demonstrating tax compliance with traditional hard-copy documents or reproductions thereof, in whole or in part, whether or not such marijuana retailer also has retained or has the capability to retain records on electronic or other storage media in accordance with this rule. However, this section shall not relieve the marijuana retailer of the obligation to comply with section (2)(b) of this rule.

(3) Recordkeeping Requirements — Machine-Sensible Records:

(a) General Requirements:

(A) Machine-sensible records used to establish tax compliance shall contain sufficient transaction-level detail information so that the details underlying the machine-sensible records can be identified and made available to the department upon request. A marijuana retailer has discretion to discard duplicated records and redundant information provided its responsibilities under this rule are met.

(B) The retained records shall be capable of being retrieved and converted to a standard record format.

(C) Marijuana retailers are not required to construct machine-sensible records other than those created in the ordinary course of business. A marijuana retailer who does not create the electronic equivalent of a traditional paper document in the ordinary course of business is not required to construct such a record for tax purposes.

(b) Electronic Data Interchange Requirements:

(A) Where a marijuana retailer uses electronic data interchange processes and technology, the level of record detail, in combination with other records related to the transactions, shall be equivalent to that contained in an acceptable paper record. The retained records should contain such information as vendor name, invoice date, product description, quantity purchased, price, amount of tax, indication of tax status, shipping detail, and any other pertinent information requested by the department. Codes may be used to identify some or all of the data elements, provided that the

marijuana retailer provides a method which allows the department to interpret the coded information.

(B) The marijuana retailer may capture the information necessary to satisfy section (3)(b)(A) of this rule at any level within the accounting system and need not retain the original EDI transaction records provided the audit trail, authenticity, and integrity of the retained records can be established. For example, a marijuana retailer using electronic data interchange technology receives electronic invoices from its suppliers. The marijuana retailer decides to retain the invoice data from completed and verified EDI transactions in its accounts payable system rather than to retain the EDI transactions themselves. Since neither the EDI transaction nor the accounts payable system captures information from the invoice pertaining to product description and vendor name (i.e., they contain only codes for that information), the marijuana retailer also retains other records, such as its vendor master file and product code description lists and makes them available to the department. In this example, the marijuana retailer need not retain its EDI transaction for tax purposes.

(c) Electronic Data Processing Systems Requirements. The requirements for an electronic data processing accounting system should be similar to that of a manual accounting system, in that an adequately designed accounting system should incorporate methods and records that will satisfy the requirements of this rule.

(d) Business Process Information:

(A) Upon the request of the department, the marijuana retailer shall provide a description of the business process that created the retained records. Such description shall include the relationship between the records and the tax documents prepared by the marijuana retailer and the measures employed to ensure the integrity of the records.

(B) The marijuana retailer shall be capable of demonstrating:

(i) The functions being performed as they relate to the flow of data through the system;

(ii) The internal controls used to ensure accurate and reliable processing; and

(iii) The internal controls used to prevent unauthorized addition, alteration, or deletion of retained records.

(C) The following specific documentation is required for machine-sensible records retained pursuant to this rule:

(i) Record formats or layouts;

(ii) Field definitions (including the meaning of all codes used to represent information);

(iii) File descriptions (e.g., data set name); and

(iv) Detailed charts of accounts and account descriptions.

(4) Records Maintenance Requirements:

(a) The department recommends but does not require that marijuana retailers refer to the National Archives and Record Administration's (NARA) standards for guidance on the maintenance and storage of electronic records, such as the labeling of records, the location and security of the storage environment, the creation of back-up copies, and the use of periodic testing to confirm the continued integrity of the records.

(b) The marijuana retailer's computer hardware or software shall accommodate the extraction and conversion of retained machine-sensible records.

(5) Access to Machine-Sensible Records:

(a) The manner in which the department is provided access to machine-sensible records as required in section (2)(b) of this rule may be satisfied through a variety of means that shall take into account a marijuana retailer's facts and circumstances through consultation with the marijuana retailer.

(b) Such access will be provided in one or more of the following ways:

(A) The marijuana retailer may arrange to provide the department with the hardware, software and personnel resources to access the machine-sensible records.

(B) The marijuana retailer may arrange for a third party to provide the hardware, software and personnel resources necessary to access the machine-sensible records.

(C) The marijuana retailer may convert the machine-sensible records to a standard record format specified by the department, including copies of files, on a magnetic medium that is agreed to by the department.

(D) The marijuana retailer and the department may agree on other means of providing access to the machine-sensible records.

(6) Marijuana Retailer Responsibility and Discretionary Authority:

(a) In conjunction with meeting the requirements of section (3) of this rule, a marijuana retailer may create files solely for the use of the department. For example, if a data-base management system is used, it is consistent with this rule for the marijuana retailer to create and retain a file that contains the transaction-level detail from the database management system and that meets the requirements of section (3) of this rule. The marijuana retailer should document the process that created the separate file to show the relationship between that file and the original records.

(b) A marijuana retailer may contract with a third party to provide custodial or management services for the records. Such a contract shall not relieve the marijuana retailer of its responsibilities under this rule.

(7) Alternative Storage Media:

(a) For purposes of storage and retention, marijuana retailers may convert hard-copy documents received or produced in the normal course of business and required to be retained under this rule to microfilm, microfiche or other storage-only imaging systems and may discard the original hard-copy documents, provided the conditions of this section are met. Documents that may be stored on these media include, but are not limited to general books of account, journals, voucher registers, general and subsidiary ledgers, and supporting records of details, such as sales invoices, purchase invoices, exemption certificates, and credit memoranda.

(b) Microfilm, microfiche and other storage-only imaging systems shall meet the following requirements:

(A) Documentation establishing the procedures for converting the hard-copy documents to microfilm, microfiche or other storage-only imaging system shall be maintained and made available on request. Such documentation shall, at a minimum, contain a sufficient description to allow an original document to be followed through the conversion system as well as internal procedures established for inspection and quality assurance.

(B) Procedures shall be established for the effective identification, processing, storage, and preservation of the stored documents and for making them available for the period they are required to be retained under section (9) of this rule.

(C) Upon request by the department, a marijuana retailer shall provide facilities and equipment for reading, locating, and reproducing any documents maintained on microfilm, microfiche or other storage-only imaging system.

(D) When displayed on such equipment or reproduced on paper, the documents shall exhibit a high degree of legibility and readability. For this purpose, legibility is defined as the quality of a letter or numeral that enables the observer to identify it positively and quickly to the exclusion of all other letters or numerals. Readability is defined as the quality of a group of letters or numerals being recognizable as words or complete numbers.

(E) All data stored on microfilm, microfiche or other storage-only imaging systems shall be maintained and arranged in a manner that permits the location of any particular record.

(F) There is no substantial evidence that the microfilm, microfiche or other storage-only imaging system lacks authenticity or integrity.

(8) Hard-Copy Recordkeeping Requirements:

(a) Except as otherwise provided in this section, the provisions of this rule do not relieve marijuana retailers of the responsibility to retain hard-copy records that are created or received in the ordinary course of business as required by existing law and rules. Hard-copy records may be retained on a recordkeeping medium as provided in section (7) of this rule.

(b) If hard-copy records are not produced or received in the ordinary course of transacting business (e.g., when the marijuana retailer uses electronic data interchange technology), such hard-copy records need not be created.

(c) Hard-copy records generated at the time of a transaction using a credit or debit card shall be retained unless all the details necessary to determine correct tax liability relating to the transaction are subsequently received and retained by the marijuana retailer in accordance with this rule. Such details include those listed in section (3)(b)(A) of this rule.

(d) Computer printouts that are created for validation, control, or other temporary purposes need not be retained.

(e) Nothing in this section shall prevent the department from requesting hard-copy printouts in lieu of retained machine-sensible records at the time of examination.

(9) Records Retention. Time Period — All records required to be retained under this rule shall be preserved pursuant to ORS 475B.700 to 475B.760 unless the department has provided in writing that the records are no longer required.

Stat. Auth.: ORS 305.100, 475B.750
Stats. Implemented: ORS 475B.755
Hist.: REV 4-2016, f. & cert. ef. 7-1-16

150-475B.740
Refund of Excess Marijuana Tax for Consumers

(1) If a consumer determines that the actual amount of marijuana tax the consumer paid to a marijuana retailer was computed on an amount that is not taxable or is in excess of the correct tax amount, the consumer may request a refund of the overpayment of marijuana tax in writing to the marijuana retailer where the excess marijuana tax was paid. The request must be mailed or delivered to the marijuana retailer within 30 days of the date of the excess tax payment.

(2) Written notification of excess marijuana tax paid and any request for refund must include the marijuana retailer's business name, nature of the excess marijuana tax paid, remedy requested and a receipt clearly identifying the date of purchase and proof of payment of the excess marijuana tax.

(3) If, within 60 days of the date of the original request for refund established in section (1), the marijuana retailer does not return the excess tax to the consumer, the consumer may appeal to the Department of Revenue by filing a written appeal within 120 days of the date of the original request for refund. An appeal to the department requires written notification to the department as outlined in section (2) of this rule.

(4) The department must refund excess marijuana taxes to a consumer when shown by satisfactory proof that:

(a) The consumer paid excess marijuana tax to a marijuana retailer;

(b) The excess marijuana tax was not refunded to the consumer by the marijuana retailer; and

(c) The consumer made a timely request for refund of excess marijuana tax paid as established in this rule.

(5) The department or marijuana retailer may not consider any request for refund of excess marijuana tax if the consumer is unable to provide a receipt that clearly identifies the date of purchase and proof of payment of the excess marijuana tax.

Stat. Auth.: ORS 305.100, 475B.750
Stats. Implemented: ORS 475B.755
Hist.: REV 4-2016, f. & cert. ef. 7-1-16

150-475B.755
100 Percent Penalty for Failure to File Marijuana Tax Returns

(1) The Department of Revenue may impose the 100 percent penalty under ORS 305.992 if:

(a) The taxpayer was required to file Oregon marijuana tax returns in at least one quarter during each tax year of three or more consecutive years; and

(b) All Oregon marijuana tax returns due during the three-year period are not filed by the due date (including extensions) of the return required for the fourth quarter of the third consecutive year. Assessments under ORS 305.265(10) are not returns for the purpose of the penalty under ORS 305.992.

(2) The filing due dates of Oregon marijuana tax returns are established under ORS 475B.710.

Stat. Auth.: ORS 305.100, 475B.750
Stats. Implemented: ORS 475B.755
Hist.: REV 4-2016, f. & cert. ef. 7-1-16

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Rule Caption: Corporate Tax: Sale of commodities by public utilities; Modified factors for publishing
Adm. Order No.: REV 5-2016
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Amended: 150-314.280-(O)
Rules Renumbered: 150-314.670-(A) to 150-314.667-(A)
Subject: 150-314.280-(O) is amended to be applicable to all periods open to examination.

150-314.670-(A) renumbered to 150-314.667-(A) to reflect a statutory change that was enacted by the Legislature.
Rules Coordinator: Lois Williams—(503) 945-8029

150-314.280-(O)
Public Utilities: Sale of Commodities

(1) The sale of a commodity such as electricity, water, steam, oil, oil products or gas, including but not limited to natural and liquid gas, which is delivered or shipped to a purchaser with a contractually specified point of physical delivery in Oregon, is a sale in this state. It does not matter whether the purchaser uses the property in Oregon, transfers the property to another state, or resells the property in Oregon. If the contract states the point of delivery is at the Oregon border with another state, the sale is presumed to be in Oregon unless the taxpayer can demonstrate to the satisfaction of the department that delivery occurred in some other place.

Example 1: A provider of wholesale electricity enters into a contract to deliver a specified amount and duration of a supply of electricity to a purchaser who takes possession at a contractually specified point of physical delivery in Oregon. The sale is an Oregon sale.

(2) A taxpayer who contracts to sell electricity to and also buy electricity from the same entity during the same period or partial period of time will have an offsetting contractual amount, also known as a book-out transaction. The gross sales of electricity, without regard to the offsetting purchase amount, are considered to be Oregon sales if the contractually specified point of physical delivery is in Oregon.

Example 2: Company A signed a contract on January 2, 2016, to purchase 50 megawatts of electricity for a period of 10 hours starting November 15, 2016, from Company B with a delivery point of Malin, Oregon. For this same time period, Company A signed a contract on March 15, 2014, to sell 30 megawatts of electricity to Company B with a point of delivery at Malin, Oregon. The 30 megawatts of power is recorded as a book-out transaction on both companies' books for reporting to Oregon. The offsetting transaction for the 30 megawatts is deemed to be delivered in Oregon for the purposes of computing the Oregon sales factor. Company A will report the sale of 30 megawatts in its Oregon sales factor numerator and Company B will report the sale of 50 megawatts (20 megawatts to complete the sales contract plus 30 megawatts from the book-out transaction) of electricity in its Oregon sales factor numerator.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 305.100, 314.280
Stats. Implemented: ORS 314.280
Hist.: REV 5-2015, f. 12-23-15, cert. ef. 1-1-16; REV 1-2016(Temp), f. 1-25-16, cert. ef. 1-26-16 thru 7-23-16; REV 5-2016, f. & cert. ef. 7-1-16

150- 314.667-(A)
Modified Factors for Publishing

The following special rules are established with respect to the apportionment of income derived from the publishing, sale, licensing or other distribution of books, newspapers, magazines, periodicals, trade journals or other printed material. The rule adopts a model regulation recommended by the Multistate Tax Commission to promote uniform treatment of these items by the states.

(1) In General. Except as specifically modified by this rule, when a person in the business of publishing, selling, licensing or distributing newspapers, magazines, periodicals, trade journals or other printed material has income from sources both within and without this state, the amount of business income from sources within this state from such business activity will be determined pursuant to ORS 314.650 through 314.665 and the rules thereunder.

(2) Definitions. The following definitions are applicable to the terms contained in this rule.

(a) "Outer-jurisdictional property" means certain types of tangible personal property, such as orbiting satellites, undersea transmission cables and the like, that are owned or rented by the taxpayer and used in the business of publishing, licensing, selling or otherwise distributing printed material, but that are not physically located in any particular state.

(b) "Print or printed material" includes, without limitation, the physical embodiment or printed version of any thought or expression including, without limitation, a play, story, article, column or other literary, commercial, educational, artistic or other written or printed work. The determination of whether an item is or consists of print or printed material will be made without regard to its content. Printed material may take the form of a book, newspaper, magazine, periodical, trade journal or any other form of printed matter and may be contained on any medium or property.

(c) "Purchaser" and "Subscriber" mean the individual, residence, business or other outlet that is the ultimate or final recipient of the print or printed material. Neither of such terms will mean or include a wholesaler or other distributor of print or printed material.

(d) "Terrestrial facility" will include any telephone line, cable, fiber optic, microwave, earth station, satellite dish, antennae or other relay system or device that is used to receive, transmit, relay or carry any data, voice, image or other information that is transmitted from or by any outer-jurisdictional property to the ultimate recipient thereof.

(3) Apportionment of Business Income.

(a) The Property Factor.

(A) Property Factor Denominator. All real and tangible personal property, including outer-jurisdictional property, whether owned or rented, that is used in the business will be included in the denominator of the property factor.

(B) Property Factor Numerator.

(i) All real and tangible personal property owned or rented by the taxpayer and used in this state during the tax period will be included in the numerator of the property factor.

(ii) Outer-jurisdictional property owned or rented by the taxpayer and used in this state during the tax period will be included in the numerator of the property factor in the ratio that the value of such property that is attributable to its use by the taxpayer in business activities in this state bears to the total value of such property that is attributable to its use in the taxpayer's business activities everywhere. The value of outer-jurisdictional property to be attributed to the numerator of the property factor of this state will be determined by the ratio that the number of uplinks and downlinks (sometimes referred to as "half-circuits") that were used during the tax period to transmit from this state and to receive in this state any data, voice, image or other information bears to the total number of uplinks and downlinks or half-circuits that the taxpayer used for transmissions everywhere. Should information regarding such uplink and downlink or half-circuit usage not be available or should such measurement of activity not be applicable to the type of outer-jurisdictional property used by the taxpayer, the value of such property to be attributed to the numerator of the property factor of this state will be determined by the ratio that the amount of time (in terms of hours and minutes of use) or such other measurement of use of outer-jurisdictional property that was used during the tax period to transmit from this state and to receive in this state any data, voice, image or other information bears to the total amount of time or other measurement of use that was used for transmissions everywhere.

(iii) Outer-jurisdictional property will be considered to have been used by the taxpayer in its business activities within this state when such property, wherever located, has been employed by the taxpayer in any manner in the publishing, sale, licensing or other distribution of books, newspapers, magazines or other printed material and any data, voice, image or other information is transmitted to or from this state either through an earth station or terrestrial facility located in this state.

Example: One example of the use of outer-jurisdictional property is where the taxpayer either owns its own communications satellite or leases the use of uplinks, downlinks or circuits or time on a communications satellite for the purpose of sending messages to its newspaper printing facilities or employees in a state. The state or states in which any printing facility that receives the satellite communications is located and the state from which the communications were sent would, under this rule, apportion the cost of the owned or rented satellite to their respective property factors based upon the ratio of the in-state use of said satellite to its total usage everywhere.

Assume that ABC Newspaper Co. owns a total of $400,000,000 of property everywhere and that, in addition, it owns and operates a communication satellite for the purpose of sending news articles to its printing plant in this state, as well as for communicating with its printing plants and facilities or news bureaus, employees and agents located in other states and throughout the world. Also assume that the total value of its real and tangible personal property that was permanently located in this state for the entire income year was valued at $3,000,000. Assume also that the total original cost of the satellite is $100,000,000 for the tax period and that of the 10,000 uplinks and downlinks of satellite transmissions used by the taxpayer during the tax period, 200 or 2% are attributable to its satellite communications received in and sent from this state.

Assume further that the company's mobile property that was used partially within this state, consisting of 40 delivery trucks, was determined to have an original cost of $4,000,000 and such mobile property was used in this state for 95 days.

The total value of property to be attributed to this state would be determined as follows:

Value of property permanently in state: $3,000,000

Value of mobile property:

95/365 (or .260274) x $4,000,000: $1,041,096

Value of leased satellite property used in-state:

.02 x $100,000,000: $2,000,000

Total value of property attributable to state: $6,041,096

Total property factor %: $6,041,096/$500,000,000: 1.2082%

(b) The Payroll Factor. The payroll factor will be determined in accordance with OAR 150-314.660 and the rules thereunder.

(c) The Sales Factor:

(A) Sales Factor Denominator. The denominator of the sales factor will include the total gross receipts derived by the taxpayer from transactions and activity in the regular course of its trade or business, except receipts that may be excluded under ORS 314.665 and the rules thereunder.

(B) Sales Factor Numerator. The numerator of the sales factor will include all gross receipts of the taxpayer from sources within this state, including, but not limited to, the following:

(i) Gross receipts derived from the sale of tangible personal property, including printed materials, delivered or shipped to a purchaser or a subscriber in this state.

(ii) Except as provided in subsection (3)(c)(B)(iii), gross receipts derived from advertising and the sale, rental or other use of the taxpayer's customer lists or any portion thereof will be attributed to this state as determined by the taxpayer's "circulation factor" during the tax period. The circulation factor will be determined for each individual publication by the taxpayer of printed material containing advertising and will be equal to the ratio that the taxpayer's in-state circulation to purchasers and subscribers of its printed material bears to its total circulation to purchasers and subscribers everywhere. The circulation factor for an individual publication will be determined by reference to the rating statistics as reflected in such sources as Audit Bureau of Circulations or other comparable sources, provided that the source selected is consistently used from year to year for such purpose. If none of the foregoing sources are available, or, if available, none is in form or content sufficient for such purposes, then the circulation factor will be determined from the taxpayer's books and records.

(iii) When specific items of advertisements can be shown, upon clear and convincing evidence, to have been distributed solely to a limited regional or local geographic area in which this state is located, the taxpayer may petition, or the Department of Revenue may require, that a portion of such receipts be attributed to the sales factor numerator of this state on the basis of a regional or local geographic area circulation factor and not upon the basis of the circulation factor provided by subparagraph (3)(c)(B)(ii). Such attribution will be based upon the ratio that the taxpayer's circulation to purchasers and subscribers located in this state of the printed material containing such specific items of advertising bears to its total circulation of such printed material to purchasers and subscribers located within such regional or local geographic area. This alternative attribution method will be permitted only upon the condition that such receipts are not double counted or otherwise included in the numerator of any other state.

(iv) In the event that the purchaser or subscriber is the United States Government or that the taxpayer is not taxable in a state, the gross receipts from all sources, including the receipts from the sale of printed material, from advertising, and from the sale, rental or other use of the taxpayer's customer's lists, or any portion thereof that would have been attributed by the circulation factor to the numerator of the sales factor for such state, will be included in the numerator of the sales factor of this state if the printed material or other property is shipped from an office, store, warehouse, factory, or other place of storage or business in this state.

Stat. Auth.: ORS 305.100 & 314.667
Stats. Implemented: ORS 314.667
Hist.: REV 11-2004, f. 12-29-04, cert. ef. 12-31-04; Renumbered from 150-314.670-(A) by REV 5-2016, f. & cert. ef. 7-1-16

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Department of State Lands
Chapter 141

Rule Caption: Establish a Removal-Fill General Permit for Navigational Access Maintenance Dredging
Adm. Order No.: DSL 4-2016
Filed with Sec. of State: 7-15-2016
Certified to be Effective: 9-1-16
Notice Publication Date: 7-1-2016
Rules Adopted: 141-093-0250, 141-093-0255, 141-093-0260, 141-093-0265, 141-093-0270, 141-093-0275, 141-093-0280
Subject: This rulemaking addresses the recommendations of Regional Solutions and small ports represented through the Oregon Public Ports Association to simplify and expedite the state removal-fill permitting requirements for navigational access maintenance dredging. The new rules create a general permit available to persons needing to conduct such maintenance dredging. Only areas that have been previously dredged and that meet other requirements specified by rule would be eligible to use the general permit.
Rules Coordinator: Sabrina L. Foward—(503) 986-5236

141-093-0250
Purpose

This General Permit authorizes removal-fill for certain activities related to navigational access maintenance dredging.

Stat. Auth.: ORS 196.817
Stats. Implemented: ORS 196.600-196.990
Hist.: DSL 4-2016, f. 7-15-16, cert. ef. 9-1-16

141-093-0255
Definitions

The following definitions are used in this General Permit, in addition to those contained in OAR 141-085:

(1) "Baseline Authorization" means a previous removal-fill authorization for a dredge prism of specified area(s) and depth(s) that was executed within fifteen (15) years of the date of application for authorization under this General Permit.

(2) "Boat" is defined in ORS 830.005.

(3) "Flowlane" means that portion of a waterway where sufficient flow velocity and depth exists to disperse placed material and not cause shoaling.

(4) "Maintenance Dredging" means an activity undertaken by a person to remove and place, in approved in-water and upland locations, accumulated sediment within previously authorized and executed dredge areas and depths ("baseline authorization") for the purpose of maintaining navigational access. If necessary and at the Department's discretion, maintenance dredging may include up to one foot of additional over-dredge depth.

(5) "Navigational Access" means operation of a boat on waters of this State.

Stat. Auth.: ORS 196.817
Stats. Implemented: ORS 196.600-196.990
Hist.: DSL 4-2016, f. 7-15-16, cert. ef. 9-1-16

141-093-0260
Eligibility Requirements

Activities authorized by this General Permit must meet all of the following requirements:

(1) Purpose. The activity must be for the purpose of maintenance dredging.

(2) No Fill in Waters. The maintenance dredging activity includes no fill in waters of this State except for:

(a) Temporary placement of equipment necessary to conduct the maintenance dredging activity (e.g., spud piles, hydraulic pipelines, anchors).

(b) Any authorized placement of removed material in the flowlane or territorial sea.

(3) Removal Method. Removal of material must be by means of hydraulic pipeline dredge or closed bucket (e.g., clamshell bucket) unless otherwise approved by the Department and upon evidence that the removal activity will not result in significant suspension of material in the water column.

Stat. Auth.: ORS 196.817
Stats. Implemented: ORS 196.600-196.990
Hist.: DSL 4-2016, f. 7-15-16, cert. ef. 9-1-16

141-093-0265
General Permit-Specific Application Requirements

In addition to the application requirements described in OAR 141-093-0105, the applicant must provide the following information in the application:

(1) Baseline Authorization; Identification of the baseline authorization(s) for the maintenance dredging activity being applied for under this General Permit.

(2) Drawings. Scaled drawing(s) illustrating the area and depths of the proposed maintenance dredging activity relative to the baseline authorization. Scaled drawings must report elevations in consistent and standard datum (e.g., NAVD 88, MLLW).

(3) Upland Placement. For upland placement, identification of the upland placement site and evidence of upland status (e.g., a valid written jurisdictional determination by the Department confirming upland status).

(4) In-water Placement. For placement in the flowlane or territorial sea, the applicant must provide a copy of findings from the Portland Sediment Evaluation Team, or any subsequently authorized body, approving in-water placement of the material.

(a) For flowlane placement, the applicant must also provide:

(A) Scaled drawing(s) clearly identifying the proposed placement area;

(B) Evaluation used by the applicant to evaluate the sufficiency of flow and depth to adequately disperse material and not cause shoaling;

(C) Evidence of coordination with OR Department of Fish and Wildlife regarding suitability of the benthic environment to receive the material; and

(D) For flowlane disposal within a federally authorized project area, evidence of coordination with the Corps' Navigation Branch to determine the potential for any impacts to navigation.

(b) For placement in the territorial sea, the applicant must also provide:

(A) Identification of the USEPA-approved placement site; and

(B) A resource inventory and effects evaluation consistent with the requirements contained in the Oregon Territorial Sea Plan, Part 2.

(5) Volumes. Volumes of material anticipated to be removed and to be placed in waters of this State per dredging event, number of dredging events anticipated over the term of the authorization, and total volumes over the term of the authorization.

Stat. Auth.: ORS 196.817
Stats. Implemented: ORS 196.600-196.990
Hist.: DSL 4-2016, f. 7-15-16, cert. ef. 9-1-16

141-093-0270
Authorized Activities

This General Permit authorizes maintenance dredging in accordance with the requirements of this Division, including the removal of material, transport of material to a placement site, and placement of material in an upland, flowlane or territorial sea location.

Stat. Auth.: ORS 196.817
Stats. Implemented: ORS 196.600-196.990
Hist.: DSL 4-2016, f. 7-15-16, cert. ef. 9-1-16

141-093-0275
General Permit-Specific Conditions

(1) General Conditions Apply. All requirements, procedures and conditions set forth in OAR 141-093-0135 (General Conditions) apply to this General Permit, except as follows:

(a) General Condition (8) Pre-construction Resource Area Fencing or Flagging does not apply; and

(b) General Condition (9) Erosion Control Methods applies only to maintenance dredging activity involving upland placement of material.

(2) Removal-General.

(a) To the extent practicable, maintenance dredging activity must be staged from an upland or vessel-mounted position. If necessary to achieve the removal, heavy equipment may be staged on or traverse impervious surfaces in the dry below ordinary high water or highest measured tide. In such case, equipment must use water quality best management practices specified in the DEQ-issued Section 401 Water Quality Certification for the project.

(b) For vessel-mounted operations, vessels must not be grounded on the bed or banks at any time.

(c) Accumulated woody debris within the maintenance dredging footprint may be removed to the extent necessary to achieve the target bathymetry.

(3) Removal by Hydraulic Pipeline Dredge.

(a) To the extent practicable and as material characteristics allow, the working end of the dredge ladder must be kept buried at a target depth of at least 24 inches below the bottom of the waterway. The intake may be raised no more than 3 feet above the bed for the minimum time necessary for purging or flushing. No back-flushing of the pipeline is allowed. No jetting of sediment is allowed unless approved by the Department pursuant to OAR 141-093-0260(3).

(b)The pipeline and any anchors or floats must be removed from the waterway immediately upon completion of the maintenance dredging activity unless another minimum necessary timeframe is approved by the Department. In no case will the pipeline, anchors, floats or other equipment be permanently placed in waters of this State.

(c) Pressure in the dredge pipeline must be continuously monitored during operation. In the event of a sudden and sustained pressure drop, dredging activity shall immediately stop. Any breach of the pipeline must be repaired prior to restarting dredging operation.

(4) Removal by Closed Bucket. To the extent material characteristics allow, the bucket must be sealed in the closed position to minimize sediment re-suspension. Moving material on the bottom to consolidate it before lifting is prohibited.

(5) Material Transport. For dredged material transported by vessel or other over-water conveyance:

(a) All dredged materials must be placed in vessels or other conveyances equipped such that no dredged material discharges to waters of this State during loading, transfer and unloading activity for upland placement.

(b) Vessels must be staged such that there is no grounding on the bed or banks at any time.

(6) Placement – General. Unless otherwise authorized by the governing regulatory agency or agencies, removed material must not be placed in any wetland, Federal Emergency Management Administration designated floodway, or in an area historically subject to landslides.

(7) Upland Placement.

(a) Removed material placed in an upland site must meet the Oregon Department of Environmental Quality definition of clean fill or the use must be specifically allowed by the Oregon Department of Environmental Quality by rule, permit, or other authorization.

(b) Waste waters from the upland placement site must have adequate settling time before being discharged into a water of this State. Water discharged from the upland placement site must meet water quality requirements of the Oregon Department of Environmental Quality.

(8) Flowlane Placement. Flowlane placement must occur on the ebb tide only and only when there is sufficient current to disperse the material to prevent shoaling.

(9) Ocean Placement. Ocean placement may only occur as authorized by a USEPA letter of concurrence.

(10) Ocean Shore Permit. If the project includes direct placement of material on the ocean shore, a separate Ocean Shore Permit, administered by Oregon Parks and Recreation Department, will be required to authorize that activity.

(11) State-Owned Waterways. Maintenance dredging in a state-owned waterway may be subject to a Short-Term Access Agreement with the Department. The placement of state-owned material on uplands is subject to a Sand and Gravel Lease or License from the Department. Any beneficial use of state-owned material may be subject to royalty payments to the Department.

(12) Fish Entrainment. The authorization holder must immediately report any fish observed that are entrained by operations to the nearest OR Department of Fish and Wildlife office. The permittee must provide access for OR Department of Fish and Wildlife staff to enter the project site for making fish entrainment observations.

(13) Post-Activity Reporting. Within 90 days of maintenance dredging completion, the authorization holder must submit to the Department a scaled drawing illustrating the actual removal area and post-removal depths achieved using the same datum as used in the application.

(14) Modifying Conditions. The Department may modify the conditions of the authorization at any time if necessary to reduce or eliminate adverse effects to water resources.

Stat. Auth.: ORS 196.817
Stats. Implemented: ORS 196.600-196.990
Hist.: DSL 4-2016, f. 7-15-16, cert. ef. 9-1-16

141-093-0280
Term and Reporting

(1) Term. Authorizations under this General Permit may be kept active for up to twenty (20) years, subject to the following conditions. Failure to meet these conditions may result in suspension or revocation of the authorization.

(a) The applicable fees are received by the Department before the anniversary date of the authorization;

(b) The authorization holder submits to the Department, every five (5) years before the anniversary date of the authorization, a status report including at least the following information:

(A) Authorization holder name and permit number;

(B) Number of dredge events and total volume of material removed during the previous five-year period;

(C) Removal method(s) and placement site(s) used; and

(D) Description of the physical conditions within the authorized dredge area at the time of report preparation: extent of submerged and submersible lands condition, extent of any vegetation including visible submerged aquatic vegetation.

Stat. Auth.: ORS 196.817
Stats. Implemented: ORS 196.600-196.990
Hist.: DSL 4-2016, f. 7-15-16, cert. ef. 9-1-16

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Department of State Police, Office of State Fire Marshal
Chapter 837

Rule Caption: Adopt, by reference, the Hazardous Substance Possession Fee schedule effective July 1, 2016.
Adm. Order No.: OSFM 1-2016
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 837-090-1030
Subject: Fee schedules are established by Office of State Fire Marshal for any person possessing a hazardous substance at a facility in this state. This rule amendment adopts, by reference, the Hazardous Substance Possession Fee schedule effective July 1, 2016.
Rules Coordinator: Valerie Abrahamson—(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 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 occurred 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, 2016. 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; OSFM 4-2014, f. & cert. ef. 7-1-14; OSFM 1-2015, f. 6-22-15, cert. ef. 7-1-15; OSFM 1-2016, f. & cert. ef. 7-1-16

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

Rule Caption: Establishes eligibility requirements, procedures for issuance of special registration plates; updates DMV group plate rules
Adm. Order No.: DMV 3-2016
Filed with Sec. of State: 6-22-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Adopted: 735-040-0045, 735-040-0110, 735-040-0115, 735-040-0120, 735-040-0125, 735-040-0130
Rules Amended: 735-040-0040
Rules Repealed: 735-040-0055, 735-040-0061, 735-040-0095, 735-040-0097, 735-040-0100
Subject: DMV issues vehicle registration plates necessary to operate motor vehicles on Oregon roads. Choices for registration plates include the standard tree plate, which is issued to all passenger vehicles unless the vehicle owner chooses a non-standard plate type. Available nonstandard plates include, veterans' recognition plates (i.e., Purple Heart and Gold Star Family), special registration plates (i.e., Pacific Wonderland, Crater Lake, Cultural and Wine Country), and group plates issued to non-profit groups and institutions of higher education under ORS 805.205 (i.e., Fallen Public Safety Officer, Share the Road, Oregon State University and University of Oregon). Each of these nonstandard plates requires the payment of an addi-

tional fee, also known as surcharge, that DMV collects upon initial registration, and, depending on the plate, at registration renewal.

In pertinent part, House Bill 2730 (2015): (1) Amended ORS 805.205 to remove statutory language pertaining to the creation of new group plates issued to non-profit groups and institutions of higher education; (2) Repealed ORS 805.202, which limited the number of specialty plates to four plates available for issuance at any one time; and (3) Established ORS 805.222 and 805.225 directing DMV to adopt rules to establish a program for the issuance of special registration plates for 501(c)(3) non-profit groups, institutions of higher education and public bodies as defined in ORS 174.109 and to adopt rules for the administration and implementation of the special registration plate program. This includes establishing:

(a) General qualification requirements for non-profit groups, institutions of higher education and public bodies that wish to become eligible for a special registration plate;

(b) When DMV may cease to issue a special registration plate; and

(c) The process to apply for a special registration plate.

The adoption of OAR 735-040-0110, 735-040-0115, 735-040-0120, 735-040-0125 and 735-040-0130 establish the procedures and requirements for the new special registration plate program. This includes general qualification requirements for organizations that wish to participate in the special registration plate program, the issuance of prepaid vouchers and the design requirements for special registration plates. The adoption of OAR 735-040-0045 sets the requirements for groups that continue to function under the old group plate program. DMV repealed the requirements for the old group program under OAR 735-040-0055, 735-040-0061, 735-0040-0095, 735-040-0097 and 735 -040-0100. The amendment of OAR 735-040-0040 updates terms and definitions to conform to the legislative Act and this rulemaking. The amendment of OAR 735-040-0040 updates terms and definitions to conform to the legislative Act and this rulemaking.

Rules Coordinator: Lauri Kunze—(503) 986-3171

735-040-0040
Definitions

As used in OAR 735-040-0040 through 735-040-0130:

(1) "Anticipated Costs," for the purposes of ORS 805.225 and this rule, means costs incurred by DMV to add a plate to the special registration plate program, including but not limited to, application review costs, computer programming costs, vendor set-up fees, plate design costs and production setup costs.

(2) "DMV" means the Driver and Motor Vehicle Services Division of the Department of Transportation.

(3) "Gold Star Family registration plate" means a registration plate issued to a surviving family member of a person killed in action during an armed conflict while serving in the Armed Forces of the United States.

(4) "Group plates" means group registration plates approved for issuance by DMV under ORS 805.205, before August 17, 2015, to an institution of higher education or non-profit group that is tax exempt under 501(c)(3) of the Internal Revenue Code.

(5) "Special registration plate" means a registration plate issued by DMV under ORS 805.222 and 805.225.

(6) "Special registration plate program" means the special registration plate program established by DMV in accordance with ORS 805.222 to 805.225 and OAR Chapter 735, Division 040.

(7) "Organization" means any nonprofit group, institution of higher education or public body that applies for or receives approval for the issuance of a special registration plate pursuant to applicable provisions of the Oregon Vehicle Code and DMV rules.

(8) "Institution of Higher Education" or "institution" means a post-secondary-institution that is:

(a) A public university listed in ORS 352.002, or

(b) An Oregon-based and accredited, community college or nonprofit private university or college.

(9) "Nonprofit group" means a nonprofit group that meets the qualifications for tax exempt status under section 501(c)(3) of the Internal Revenue Code.

(10) "An expression of political opinion" includes, but is not limited to, any artwork, image, name, logo, mark, slogan, letter or word that expresses or suggests a viewpoint related to:

(a) A candidate for election, measure or petition;

(b) A person, group or subject associated with politics or the political process; or

(c) A social issue or cause that is divisive, and, as a result, becomes a political issue, for example, abortion, immigration or the environment.

(11) "An expression of religious belief" includes, but is not limited to, any artwork, image, name, logo, mark, slogan, letter or word that affirms or supports a particular religion or creed, expresses adherence to a particular religious sect or denomination, expresses belief in or the absence of belief in a supreme being or promotes or discourages any form of exercise of religion.

(12) "Public body" has the same meaning as set forth in ORS 174.109.

(13) "Veterans' group" as used in ORS 805.105 and Division 40 rules, means a group or organization that meets the qualifications for veterans' recognition registration plates under OAR 735-040-0080.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 805.205, 805.105, 805.222 & 805.225
Stats. Implemented: ORS 805.205, 805.105, 805.222 & 805.225
Hist.: DMV 2-1994, f. & cert. ef. 3-17-94; DMV 3-1995, f. 3-9-95, cert. ef. 3-20-95; DMV 22-2007(Temp), f. 12-24-07, cert. ef. 1-1-08 thru 6-27-08; DMV 14-2008, f. & cert. ef. 6-23-08; DVM 3-2016, f. 6-22-16, cert. ef. 7-1-16

735-040-0045
Group Registration Plates; Nonprofit Groups and Institutions of Higher Education; Approved Before August 12, 2015

(1) Effective August 12, 2015, chapter 806, Oregon Laws 2015, eliminated the creation of new group registration plates under ORS 805.205. This rule sets forth the eligibility requirements for current, active and inactive nonprofit groups and institutions of higher education (collectively referred to in this rule as "group") approved for the issuance of group registration plates before the effective date of the legislative act.

(2) To remain eligible for the issuance of group registration plates, a group described under section (1) of this rule must:

(a) Maintain documentation sufficient to demonstrate to DMV that:

(A) For a nonprofit group, the group meets the qualifications for tax exempt status under section 501(c)(3) of the Internal Revenue Code;

(B) For a group that is an institution of higher education, the group meets the definition in OAR 735-040-0040(5);

(C) For a group representing an institution of higher education, the group has written authorization from the institution to obtain higher education group plates on behalf of that institution;

(D) The group has established membership, officers and bylaws, and the group, or a chapter of the group is physically located in Oregon;

(E) The group is authorized to use any artwork, image, name, logo, mark, slogan, letter or word that appears on the group's plate; and

(F) The information submitted to DMV regarding the financial institution selected by the group for the deposit of plate surcharge amounts collected by DMV from the sale of the group's plate is up-to-date.

(b) Maintain and provide to DMV the current name, address and phone number of:

(A) Each group official, officer or director; and

(B) The person authorized by the group to act as the group's representative for purposes of the group's plate.

(c) Submit an Annual Statement of Continuing Eligibility (DMV Form 735-6942) to DMV certifying the group continues to meet the requirements for group plates under ORS 805.205 and DMV rules. The statement is due no later than 30 days after the date of receiving an annual renewal of eligibility letter from DMV.

(3) DMV may request a group to provide any information it considers necessary to verify the group is eligible for the issuance of group plates.

(4) DMV will withdraw the group's eligibility and cease to issue a group's plate if:

(a) The group fails to meet any requirement under section (2) of this rule;

(b) The group fails to provide any information requested by DMV;

(c) The group is not authorized to use an image, name, logo or design that appears on the group's plate;

(d) The group fails to submit an Annual Statement of Continuing Eligibility form as required under subsection (2)(c) of this rule; or

(e) The group fails to meet or comply with any other requirements for group plates under ORS 805.205 or DMV rule.

(5) DMV shall cease production of a group's plate if:

(a) DMV does not sell or issue renewal for 500 sets of the group's plate in any one year. For purposes of this subsection, the year begins on the first day of the month the group's plate was initially available for sale;

(b) The group ceases to exist or becomes ineligible for the issuance of special registration plates under ORS 805.205, or DMV rule; or

(c) DMV determines any artwork, image, name, logo, mark, slogan, letter or word that appears on the group's plate contains an expression of political opinion, religious belief, or violates any provision of the Oregon Vehicle Code, or DMV rule relating to registration plate content.

(6) Except for the reason described in subsection (5)(a) of this rule, when DMV ceases production of a group's plate it will destroy all remaining plate inventory.

(7) DMV will notify the group in writing if DMV withdraws the group's eligibility or ceases production or issuance of the group's plate.

(8) The group must notify DMV immediately if:

(a) There is a change in any information listed on the group's most recent application or annual eligibility statement; or

(b) The group ceases to exist or no longer meets the eligibility requirements for a nonprofit group under ORS 805.205 or DMV rule.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 805.205
Stats. Implemented: ORS 805.205
Hist.: DVM 3-2016, f. 6-22-16, cert. ef. 7-1-16

735-040-0110
Special Registration Plates; Nonprofit Groups, Qualifications; Application, Approval

(1) A nonprofit group that wishes to become eligible for a special registration plate issued under ORS 805.222 and 805.225, must submit the following to DMV:

(a) A completed and signed Application for Special Registration Plate (DMV Form 735-7076), a copy of the nonprofit group's bylaws, and documentation sufficient to demonstrate to DMV that:

(A) The nonprofit group meets the qualifications for tax exempt status under section 501(c)(3) of the Internal Revenue Code, including the nonprofit group's articles of incorporation and an IRS exemption determination letter, or similar IRS document granting the nonprofit group tax exempt status, and containing the nonprofit group's federal or IRS identification number; and

(B) The nonprofit group, or a chapter of the nonprofit group, is physically located in Oregon.

(b) The name, address, phone number and email address of current directors or officers of the nonprofit group, or other person authorized by the nonprofit group to act as the nonprofit group's representative for purposes of the nonprofit group's special registration plate.

(c) The nonprofit group's requested plate design, in an electronic format designated by the department. The design must comply with the plate design requirements specified in OAR 735-040-0125.

(d) For a nonprofit group representing an institution of higher education, written authorization from the institution stating the nonprofit group is eligible to obtain a special registration plate on behalf of that institution.

(e) A $5,000 preapproval fee to cover DMV's costs to review the group's application and requested plate design for compliance with ORS 805.222 to ORS 805.225, and DMV rules. The fee must be in the form of a check or money order payable to Oregon DMV.

(f) Any other information DMV considers necessary to determine the group is eligible for the issuance of a special registration plate.

(2) Applications and plate designs are reviewed in the order received by DMV.

(3) DMV will not issue special registration plates for a nonprofit group with a plate currently issued by DMV under ORS 805.205 and OAR 735-040-0045 until:

(a) The inventory of the nonprofit group's plate is depleted; or

(b) The nonprofit group reimburses DMV's plate manufacturing costs and any costs associated with the destruction of any remaining inventory of the nonprofit group's plate.

(4) DMV may deny a nonprofit group's eligibility for a special registration plate if:

(a) The nonprofit group's application is incomplete or contains false information;

(b) The nonprofit group is not authorized to use the requested plate design;

(c) The requested plate design does not meet the requirements specified in OAR 735-040-0125 (plate design); or

(d) The nonprofit group fails to provide any information requested by DMV, or fails to meet any requirement of the special registration plate program under ORS 805.222 to 805.225, or DMV rule.

(5) DMV will notify the nonprofit group in writing if:

(a) The nonprofit group's application or requested plate design requires additional information or modification.

(b) DMV approves the nonprofit group's application or requested plate design.

(c) DMV denies the nonprofit group's application or requested plate design.

(d) DMV withdraws the nonprofit group's eligibility or ceases production or issuance of the nonprofit group's plate.

(6) Upon DMV's approval of the nonprofit group's application and requested plate design, DMV will send the group 3,100 sequentially numbered, three-part DMV voucher forms for collection, as specified in ORS 805.225. Once collected, the group must submit at least 3,000 vouchers and all of the following to DMV:

(a) A fully executed licensing agreement between DMV and the nonprofit group for the use of any artwork, image, name, logo, mark, slogan, letter or word requested to appear on the nonprofit group's plate;

(b) A check or money order in an amount that includes:

(A) At least $120,000, with the total amount determined by the number of vouchers sold multiplied by the $40 surcharge fee; and

(B) DMV's anticipated costs of adding the nonprofit group's plate to the special registration plate program. When estimating DMV's anticipated costs, the department will include the remaining balance of any unexpended preapproval fees paid to DMV under section (1)(e) of this rule.

(c) The "DMV Copy" of each prepaid voucher form;

(d) Any unsold or voided voucher forms;

(e) A reconciliation report showing:

(A) The total number of vouchers sold, including the beginning and ending control numbers);

(B) The total number of vouchers that were lost, stolen, destroyed or voided and the control number of each;

(C) The total number of unsold vouchers; and

(D) Any additional vouchers ordered and received from DMV, including the beginning and ending control numbers;

(f) The name of the financial institution and account number designated by the nonprofit group for the deposit of plate surcharge fees (minus DMV's administrative costs) collected by DMV from the sale of the group's special registration plate; and

(g) The nonprofit group's final approved plate design, in an electronic format designated by the department.

(7) The fees submitted to DMV under subparagraph (6)(a)(A) of this rule are nonrefundable.

(8) An eligible nonprofit group must submit an Annual Statement of Continuing Eligibility (DMV Form 735-6942) to DMV certifying the group continues to meet the requirements for a special registration plate under ORS 805.222 to 805.225, and DMV rules. The statement is due no later than 30 days after the date of receiving an annual renewal of eligibility letter from DMV.

(9) The nonprofit group must notify DMV immediately if:

(a) There is a change in any information listed on the nonprofit group's application or most recent statement of continuing eligibility; or

(b) The nonprofit group ceases to exist, or no longer meets the eligibility requirements for a nonprofit group under ORS 805.222 to 805.225, or DMV rule.

(10) DMV may withdraw eligibility and cease to issue a nonprofit group's special registration plate if:

(a) The nonprofit group fails to provide any information requested by DMV;

(b) DMV determines the nonprofit group is not authorized to reproduce or use any artwork, image, name, logo, mark, slogan, letter or word previously approved for the nonprofit group's plate;

(c) The nonprofit group fails to submit an Annual Statement of Continuing Eligibility form as required under section (8) of this rule; or

(d) The nonprofit group fails to comply with any requirement for a special registration plate under ORS 805.222 to 805.225, or DMV rule.

(11) DMV shall cease production of a nonprofit group's plate if:

(a) DMV does not issue 2,000 sets of the nonprofit group's plate in any one year. For purposes of this subsection, the year begins on the day that the group's special registration plate is initially offered for sale;

(b) The group ceases to exist or becomes ineligible for the issuance of special registration plates under ORS 805.222 to 805.225, or DMV rule; or

(c) DMV determines any artwork, image, name, logo, mark, slogan, letter or word that appears on the group's plate contains an expression of political opinion or religious belief, or violates any provision of the Oregon Vehicle Code, or DMV rule relating to registration plate content.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.535, 805.222 & 805.225
Stats. Implemented: 805.222 & 805.225
Hist.: DVM 3-2016, f. 6-22-16, cert. ef. 7-1-16

735-040-0115

Special Registration Plates; Institutions of Higher Education, Qualifications; Application, Approval

(1) An institution of higher education that wishes to become eligible for a special registration plate issued under ORS 805.222 and 805.225, must submit the following to DMV:

(a) A completed and signed Application for Special Registration Plate (DMV Form 735-7076) and documentation sufficient to DMV that:

(A) The institution is an "institution" as defined in OAR 735-040-0040, including a written certification on the institution's letterhead from the institution's president, chancellor, or chief executive officer stating that the institution meets the definition of an institution of higher education as defined in OAR 735-040-0040; and

(B) The institution is physically located in Oregon.

(b) The name, address, phone number and email address of current directors or officers of the institution, or other person authorized by the institution to act as the institution's representative for purposes of the institution's special registration plate.

(c) The institution's requested plate design, in an electronic format designated by the department. The design must comply with the plate design requirements specified in OAR 735-040-0125.

(d) A $5,000 preapproval fee to cover DMV's costs to review the institution's application and requested plate design for compliance with ORS 805.222 to 805.225, and DMV rules. The fee must be in the form of a check or money order payable to Oregon DMV.

(e) Any other information DMV considers necessary to determine the institution is eligible for the issuance of a special registration plate.

(2) Applications and plate designs are reviewed in the order received by DMV.

(3) DMV will not accept an application for special registration plates from an institution with a plate currently issued by DMV under ORS 805.205 and OAR 735-040-0045 until:

(a) The inventory of the institution's plate is depleted; or

(b) The institution reimburses DMV's plate manufacturing costs and any costs associated with the destruction of any remaining inventory of the institution's plate.

(4) DMV may deny an institution's eligibility for a special registration plate if:

(a) The institution's application is incomplete or contains false information;

(b) The institution is not authorized to use the requested plate design;

(c) The requested plate design does not meet the requirements specified in OAR 735-040-0125 (plate design); or

(d) The institution fails to provide any information requested by DMV, or fails to meet any requirement for a special registration plate under ORS 805.222 or 805.225, or DMV rule.

(5) DMV will notify the institution in writing if:

(a) The institution's application or requested plate design requires additional information or modification.

(b) DMV approves the institution's application or requested plate design.

(c) DMV denies the institution's application or requested plate design.

(d) DMV withdraws the institution's eligibility or ceases production or issuance of the institution's plate.

(6) Upon DMV's approval of the institution's application and requested plate design, DMV will send the institution 3,100 sequentially numbered, three-part DMV voucher forms for collection, as specified in ORS 805.225. Once collected, the institution must submit at least 3,000 vouchers and all of the following to DMV:

(a) A fully executed licensing agreement between DMV and the institution for the use of any artwork, image, name, logo, mark, slogan, letter or word requested to appear on the institution's plate;

(b) A check or money order in an amount that includes:

(A) At least $120,000, with the total amount determined by the number of vouchers sold multiplied by the $40 surcharge fee; and

(B) DMV's anticipated costs of adding the institution's plate to the special registration plate program. When estimating DMV's anticipated costs, the department will consider the balance of any unexpended preapproval fees provided under section (1)(d) of this rule.

(c) The "DMV Copy" of each prepaid voucher form;

(d) Any unsold or voided voucher forms;

(e) A reconciliation report showing:

(A) The total number of vouchers sold, including the beginning and ending control numbers;

(B) The total number of vouchers that were lost, stolen, destroyed or voided and the control number of each;

(C) The total number of unsold vouchers; and

(D) Any additional vouchers ordered and received from DMV, including the beginning and ending control numbers.

(f) The name of the financial institution and account number designated by the institution for the deposit of plate surcharge fees (minus DMV's administrative costs) collected by DMV from the sale of the institution's special registration plate; and

(g) The institution's final approved plate design, in an electronic format designated by the department.

(7) The fees submitted to DMV under subparagraph (6)(a)(A) of this rule are nonrefundable.

(8) An eligible institution must submit an Annual Statement of Continuing Eligibility (DMV Form 735-6942) to DMV certifying the institution continues to meet the requirements for a special registration plate under ORS 805.222 to 805.225, and DMV rules. The statement is due no later than 30 days after the date of receiving an annual renewal of eligibility letter from DMV.

(9) The institution must notify DMV immediately if:

(a) There is a change in any information listed on the institution's application or most recent statement of continuing eligibility; or

(b) The institution ceases to exist, or no longer meets the eligibility requirements for a nonprofit institution under ORS 805.222 to 805.225 or DMV rule.

(10) DMV may withdraw eligibility and cease to issue an institution's special registration plate if:

(a) The institution fails to provide any information requested by DMV;

(b) DMV determines the institution is not authorized to reproduce or use any artwork, image, name, logo, mark, slogan, letter or word previously approved for the institution's plate;

(c) The institution fails to submit an Annual Statement of Continuing Eligibility form as required under section (9) of this rule; or

(d) The institution fails to comply with any requirement for a special registration plate under ORS 805.222 to 805.225, or DMV rule.

(11) DMV shall cease production of an institution's plate if:

(a) DMV does not issue 2,000 sets of the institution's plate in any one year. For purposes of this subsection, the year begins on the day that the institution's special registration plate is initially offered for sale;

(b) The institution ceases to exist or becomes ineligible for the issuance of special registration plates under ORS 805.222 to 805.225, or DMV rule; or

(c) DMV determines any artwork, image, name, logo, mark, slogan, letter or word that appears on the institution's plate contains an expression of political opinion or religious belief, or violates any provision of the Oregon Vehicle Code, or DMV rule relating to registration plate content.

(12) Except for the reason described in subsection (11)(a) of this rule, when DMV ceases production of an institution's plate it will destroy all remaining plate inventory.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.535, 805.222 & 805.225
Stats. Implemented: 805.222 & 805.225
Hist.: DVM 3-2016, f. 6-22-16, cert. ef. 7-1-16

735-040-0120

Special Registration Plates; Public Bodies, Qualifications; Application, Approval

(1) A public body that wishes to become eligible for a special registration plate issued under ORS 805.222 and 805.225 must submit the following to DMV:

(a) A completed and signed Application for Special Registration Plate (DMV Form 735-7076) and documentation sufficient to demonstrate to DMV that:

(A) The public body is a "public body" as defined in ORS 174.109 and OAR 735-040-0040, including a written certification on the public body's letterhead from an authorized representative of the public body stating the public body is authorized by law to apply for a special registration plate and to allocate the funds necessary to obtain a special registration plate. The public body must provide the citation of the applicable law in its certification.

(B) The public body, or an office of the public body, is physically located in Oregon.

(b) The name, address, phone number and email address of current directors or officers of the public body, or other person authorized by the public body to act as the public body's representative for purposes of the public body's special registration plate.

(c) The public body's requested plate design, in an electronic format designated by the department. The design must comply with the plate design requirements specified in OAR 735-040-0125.

(d) A $5,000 preapproval fee to cover DMV's costs to review, and approve or deny the public body's application and requested plate design for compliance with ORS 805.222, 805.225, and DMV rules. The fee must be in the form of a check or money order payable to Oregon DMV.

(e) Any other information DMV considers necessary to determine the public body is eligible for the issuance of a special registration plate.

(2) Applications and plate designs are reviewed in the order received by DMV.

(3) DMV may deny a public body's eligibility for a special registration plate if:

(a) The public body's application is incomplete or contains false information;

(b) The public body is not authorized to use the requested plate design;

(c) The requested plate design does not meet the requirements specified in OAR 735-040-0125 (plate design); or

(d) The public body fails to provide any information requested by DMV, or fails to meet any requirement for a special registration plate under ORS 805.222 to 805.225, or DMV rule.

(4) DMV will notify the public body in writing if:

(a) The public body's application or requested plate design requires additional information or modification;

(b) DMV approves the public body's application or requested plate design;

(c) DMV denies the public body's application or requested plate design; or

(d) DMV withdraws the public body's eligibility or ceases production or issuance of the public body's plate.

(5) Upon DMV's approval of the public body's application and requested plate design, DMV will send the public body 3,100 sequentially numbered, three-part DMV voucher forms for collection, as specified in ORS 805.225. Once collected, the public body must submit at least 3,000 vouchers and all of the following to DMV:

(a) A fully executed licensing agreement between and DMV and the public body, for the use of any artwork, image, name, logo, mark, slogan, letter or word requested to appear on the public body's plate;

(b) A check or money order in an amount that includes:

(A) At least $120,000, with the total amount determined by the number of vouchers sold multiplied by the $40 surcharge fee; and

(B) DMV's anticipated costs of adding the public body's plate to the special registration plate program. When estimating DMV's anticipated costs, the department will consider the balance of any unexpended preapproval fees provided under section (1)(d) of this rule.

(c) The "DMV Copy" of each prepaid voucher form;

(d) Any unsold or voided voucher forms;

(e) A reconciliation report showing:

(A) The total number of vouchers sold, including the beginning and ending control numbers;

(B) The total number of vouchers that were lost, stolen, destroyed or voided and the control number of each;

(C) The total number of unsold vouchers; and

(D) Any additional vouchers ordered and received from DMV, including the beginning and ending control numbers.

(f) The name of the financial institution and account number designated by the public body for the deposit of plate surcharge fees (minus DMV's administrative costs) collected by DMV from the sale of the public body's special registration plate; and

(g) The public body's final approved plate design, in an electronic format designated by the department.

(6) The fees submitted to DMV under subparagraph (5)(a)(A) of this rule are nonrefundable.

(7) An eligible public body must submit an Annual Statement of Continuing Eligibility (DMV Form 735-6942) to DMV, certifying the public body continues to meet the requirements for a special registration plate under ORS 805.222 to 805.225, and DMV rules. The statement is due no later than 30 days after the date of receiving an annual renewal of eligibility letter from DMV.

(8) The public body must notify DMV immediately if:

(a) There is a change in any information listed on the public body's application or most recent statement of continuing eligibility; or

(b) The public body ceases to exist, or no longer meets the eligibility requirements for a public body under ORS 805.222 to 805.225 or DMV rule.

(9) DMV may withdraw eligibility and cease to issue a public body's special registration plate if:

(a) The public body fails to provide any information requested by DMV;

(b) DMV determines the public body is not authorized to reproduce or use any artwork, image, name, logo, mark, slogan, letter or word previously approved for the public body's plate;

(c) The public body fails to submit an Annual Statement of Continuing Eligibility form as required under section (7) of this rule; or

(d) The public body fails to comply with any requirement for a special registration plate under ORS 805.222 to 805.225, or DMV rule.

(10) DMV shall cease production of a public body's plate if:

(a) DMV does not issue 2,000 sets of the public body's plate in any one year. For purposes of this subsection, the year begins on the day that the public body's special registration plate is initially offered for sale;

(b) The public body ceases to exist or becomes ineligible for the issuance of special registration plates under ORS 805.222 to 805.225 or DMV rule; or

(c) DMV determines any artwork, image, name, logo, mark, slogan, letter or word that appears on the public body's plate contains an expression of political opinion or religious belief, or violates any provision of the Oregon Vehicle Code, or DMV rule relating to registration plate content.

(11) Except for the reason described in subsection (10)(a) of this rule, when DMV ceases production of a public body's plate it will destroy all remaining plate inventory.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.535, 805.222 & 805.225
Stats. Implemented: 805.222 & 805.225
Hist.: DVM 3-2016, f. 6-22-16, cert. ef. 7-1-16

735-040-0125
Special Registration Plate Design

This rule establishes the plate design requirements for a special registration plate issued by DMV under ORS 805.222 to 805.225, and Division 040 rules. In addition to any other requirement for registration plates, a special registration plate design:

(1) Must be developed by DMV in consultation with an eligible organization approved by DMV under OAR 735-040-0110, 735-040-0115, or 735-040-0120, whichever is applicable;

(2) Must be legible and clearly identifiable by law enforcement personnel as a State of Oregon vehicle registration plate. DMV will consult with Oregon law enforcement for compliance with this subsection;

(3) Must contain numbers, letters, colors and artwork that have been approved by DMV;

(4) May not conflict with, or be substantially similar or identical to any existing Oregon registration plate;

(5) Must comply with the requirements for plate size, form, arrangement and materials under ORS 803.535. The registration plate dimensions described in the example Plate Diagram (revised 07-16) are adopted by reference as Appendix A;

(6) May not infringe or violate a trademark, trade name, service mark, copyright or other proprietary right;

(7) May not contain an expression of political opinion or religious belief; and

(8) May not contain any word, combination of words or image that by reasonable standards is offensive, vulgar, or an expression of contempt for a specific race, religion, ethnicity, gender, sexual orientation, disability or that refers to a controlled substance, alcoholic beverage, illegal activity or substance, or promotes or endorses a product, brand or service provided for sale.

(9) DMV will approve or deny plate designs in accordance with OAR 735-040-0110, 735-040-0115 or 735-040-0120.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.535, 805.222 & 805.225
Stats. Implemented: 805.222 & 805.225
Hist.: DVM 3-2016, f. 6-22-16, cert. ef. 7-1-16

735-040-0130
Procedures for the Sale of Special Registration Plate Vouchers

This rule describes the procedures and requirements for an organization approved by DMV to sell special registration plate vouchers, as authorized by ORS 805.222 and 805.225. An organization must comply with all of the following:

(1) The organization may only sell vouchers issued by and obtained directly from DMV.

(2) Vouchers may not be sold for an amount other than the surcharge amount established under ORS 805.222.

(3) Each voucher sold must be legibly completed with the following information:

(a) The date of sale;

(b) The name, address, phone number and email address, if available, of the person purchasing the voucher (purchaser);

(c) The printed name and signature of the person who sells the voucher on behalf of the organization (seller); and

(d) The purchaser's signature acknowledging the purchaser has read and understands the terms and conditions printed on the voucher.

(e) If transferring the voucher:

(A) The name, address, phone number and email address, if available, of the person receiving the voucher; and

(B) The signature of the purchaser authorizing the transfer.

(4) Upon the sale of a voucher, the seller must provide the purchaser the "PURCHASER'S COPY" of the voucher.

(5) An organization is solely responsible for:

(a) The safety and security of all vouchers and fees collected by the organization from the sale of vouchers;

(b) Immediately reporting any lost or stolen vouchers to DMV;

(c) Marking "VOID" on any voucher that is damaged, altered, or that contains an illegible control number or an error made by the seller or purchaser during the sale;

(d) Responding to questions and resolving any disputes with purchasers regarding:

(A) The organization's voucher sales or the fees collected by the organization from the sale of the organization's vouchers;

(B) The organization's policy on refunding fees collected by the organization from the sale of the organization's vouchers; and

(C) The status or progress of the organization's effort to obtain a special registration plate.

(6) The organization must return all void and unsold vouchers to DMV when:

(a) It submits all collected vouchers, required fees and DMV's anticipated costs of adding the organization's plate to the special registration plate program, as required under ORS 805.225, and as described in OAR 735-040-0110, 735-040-0115 or 735-040-0120, whichever is applicable;

(b) The organization notifies DMV that the organization has abandoned its effort to collect vouchers and obtain a special registration plate; or

(c) DMV determines the organization is no longer eligible for the special registration plate program.

(7) An organization may obtain additional vouchers by contacting DMV.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.535, 805.222 & 805.225
Stats. Implemented: 805.222 & 805.225
Hist.: DVM 3-2016, f. 6-22-16, cert. ef. 7-1-16

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Department of Transportation, Highway Division
Chapter 734

Rule Caption: Rest Area Sponsorship Acknowledgement Sign Program
Adm. Order No.: HWD 2-2016
Filed with Sec. of State: 6-21-2016
Certified to be Effective: 6-21-16
Notice Publication Date: 5-1-2016
Rules Adopted: 734-031-0001, 734-031-0005, 734-031-0010, 734-031-0015, 734-031-0020, 734-031-0025, 734-031-0030
Subject: The Department of Transportation provides rest areas as part of the state highway system to offer a stopping place for travelers to take a short break from driving. Many of those rest areas are managed by the Oregon Travel Information Council (TIC). There is interest in seeking sponsorship contributions to support the development, maintenance, and operation of rest areas and to acknowledge those contributions with a sign either in the rest area or on the adjacent state highway. Federal regulations pertaining to state highways allow state transportation agencies to use signs to acknowledge sponsorships provided the state transportation agency has an acknowledgement sign program.

These newly adopted rules outline the program developed by the Department of Transportation in compliance with Federal Policy 5160.1A, Sponsorship Acknowledgement and Agreements within the Highway Right of Way and will provide citizens of Oregon an opportunity to contribute support for the development or ongoing operation and maintenance of Department of Transportation rest areas. Sponsorships will be solicited using a competitive process such as a request for proposal with the successful entity selected based on a net benefit for the public. Under these rules, an acknowledgement sign may be offered in exchange for the sponsor's contribution.
Rules Coordinator: Lauri Kunze—(503) 986-3171

734-031-0001
Purpose and Scope

(1) The purpose of Division 31 rules is to establish a Rest Area Sponsorship Acknowledgement program in compliance with 23 USC 111 and the Federal Policy on Sponsorship Acknowledgement and Agreements within the Highway Right of Way that provides citizens of Oregon an opportunity to contribute money, Highway Related Services or Products to support the development or ongoing operation and maintenance of the Oregon Department of Transportation's Rest Areas.

(2) An Acknowledgement Sign may be placed to recognize the Contribution when the Contribution represents a commitment of the Participant to provide for development of a Rest Area or ongoing operation or maintenance of a Rest Area. Contributions that do not meet the criteria in Division 31 rules may be recognized by means other than an onsite Acknowledgement Sign such as a letter of recognition, press release or other outreach materials, and web sites as determined appropriate by the Rest Area Operator consistent with federal and state regulations.

(3) When a Rest Area is managed by the Travel Information Council or other entity by agreement with the Department, that agency or entity will be responsible for soliciting sponsorship Contributions and any acknowledgement of those Contributions following the program established in Division 31 rules.

(4) All Contributions received through Rest Area sponsorships are assets of the Highway Trust Fund and shall only be used for highway purposes to facilitate the development or ongoing operation and maintenance of state highway Rest Areas.

Stat. Auth.: ORS 184.616, 184.619, 366.205
Other Authority: Federal Policy 5160.1A
Stats. Implemented: ORS 366.205
Hist.: HWD 2-2016, f. & cert. ef. 6-21-16

734-031-0005
Definitions

As used in Division 31 rules, the following definitions will apply:

(1) "Acknowledgment Sign" — A sign that informs the public that a Participant has provided a Contribution for the development or ongoing operation or maintenance of an Oregon Department of Transportation Rest Area. For the purposes of Division 31 rules, an "Acknowledgment Sign" includes an acknowledgement plaque or rider added to an existing sign on the mainline highway.

(2) "Contribution" — The provision of money, highway related service, or product for the development or ongoing operation or maintenance of a Rest Area.

(3) "Department" — The Oregon Department of Transportation (ODOT).

(4) "Highway Related Service" — A service that supports the development, operation or maintenance of the Rest Area. Typical services include but are not limited to litter pickup, landscape maintenance, or brush removal.

(5) "MUTCD" — Manual on Uniform Traffic Control Devices for Streets and Highways along with the Oregon MUTCD Supplements.

(6) "Oregon Temporary Traffic Control Handbook" — The standards adopted by the Department for traffic control operations of three days or less.

(7) "Participant" — An individual, family group, company, business, or volunteer group who provide a Contribution and who has entered into a Sponsorship Agreement. "Participant" includes the organization and its members.

(8) "Product" — Items used in the development, operation or maintenance of the Rest Area by the Rest Area Operator. Typical products include but are not limited to landscape materials or building supplies.

(9) "Rest Area" — A roadside area separated from the main travel way and under the control of the Department. A Rest Area may include rest rooms, drinking water, and other facilities needed for the rest and safety of motorists. For the purposes of Division 31 rules, when a Rest Area is sited

on both sides of the highway, the two sides will be considered as separate Rest Areas.

(10) "Rest Area Operator" — The Department or Travel Information Council or other entity responsible for management of the Rest Area by agreement with the Department.

(11) "Sponsorship Agreement" —An agreement between a Participant and the Rest Area Operator where the Participant agrees to provide a Contribution in exchange for the placement of an Acknowledgement Sign in the Rest Area or on the mainline of the adjoining state highway.

Stat. Auth.: ORS 184.616, 184.619, 366.205
Other Authority: Federal Policy 5160.1A
Stats. Implemented: ORS 366.205
Hist.: HWD 2-2016, f. & cert. ef. 6-21-16

734-031-0010
Participant Eligibility

(1) An individual, family group, company, business, or volunteer group is eligible to submit proposals to provide a Contribution for the development or ongoing operation or maintenance of Rest Areas. Participants must comply with all applicable state and federal laws concerning the provisions prohibiting discrimination based on race, religion, color, age, sex, and national origin.

(2) When the Participant is a family group, company, business, or volunteer group, the Participant must appoint or select a spokesperson to act as their representative in matters relating to the sponsorship solicitation and Sponsorship Agreement. The Participant and its spokesperson are responsible for assuring compliance with the Sponsorship Agreement.

(3) Participants may provide Contributions for the overall support of one or more Rest Areas or for one or more features of a Rest Area.

Stat. Auth.: ORS 184.616, 184.619, 366.205
Other Authority: Federal Policy 5160.1A
Stats. Implemented: ORS 366.205
Hist.: HWD 2-2016, f. & cert. ef. 6-21-16

734-031-0015
Participant Selection

(1) Solicited Contributions

(a) Participants will be identified using an open, competitive solicitation process such as a request for proposal.

(b) Solicitations will provide a description of the sponsorship opportunity being offered stating all information pertinent to an understanding of the offer.

(c) When the offer is for a Highway Related Service that includes removal of noxious weeds, a plan approved in writing by the Oregon Department of Agriculture or the appropriate county governing body must be included with the proposal. The plan must include the species of plant to be removed, the method of removal that does not include the use of pesticides, herbicides, or machine powered equipment, and the timing and frequency of noxious weed removal.

(d) Successful Participants will be selected based on a net benefit for the public. There may be more than one Participant providing Contributions in support of a Rest Area or a Rest Area feature; however only one Participant will be selected for the overall sponsorship of a Rest Area. The Rest Area Operator reserves the right to reject any or all proposals if it determines the proposal is not a reasonable value or is not in the public's best interest.

(2) The decision to solicit Contributions for sponsorship of Rest Areas shall be at the discretion of the Rest Area Operator. The Rest Area Operator may consider factors such as the nature of the offered Product or Highway Related Service and the location of the proposed work in determining eligibility of a Rest Area or Rest Area feature for sponsorship.

(3) A Sponsorship Agreement will be executed by the Participant and the Rest Area Operator. The Sponsorship Agreement will list the specific requirements and obligations of both the Participant and the Rest Area Operator.

Stat. Auth.: ORS 184.616, 184.619, 366.205
Other Authority: Federal Policy 5160.1A
Stats. Implemented: ORS 366.205
Hist.: HWD 2-2016, f. & cert. ef. 6-21-16

734-031-0020
Acknowledgement Signs

(1) A sign may be placed by the Rest Area Operator informing the public of the Participant's Contribution with the Participant's name or acronym when the Contribution meets the requirements of Division 31 rules. The Participant may be required to provide evidence of the Participant's existence such as the Participant's organizational bylaws, website, or letterhead. When the Participant is an individual or family group, the individual's name (first name or initial and last name) or the family name (e.g. Smith Family) will be used.

(2) The Acknowledgement Sign shall not be used for advertising or as a memorial and shall not contain items such as contact information, directions, slogans, telephone numbers, website, or internet addresses. The Participant name may be verified with the Secretary of State's business name registry or other information available to the Rest Area Operator.

(3) The Acknowledgement Sign may be installed after the Participant has provided the monetary or product Contribution, or has successfully performed the Highway Related Service described in the Sponsorship Agreement at least once.

(4) In addition to the Contribution, the Participant will be responsible for the Rest Area Operator's cost to manufacture and install the Acknowledgement Sign. The sign will remain the property of the Rest Area Operator and be removed by the Rest Area Operator when the Sponsorship Agreement is cancelled or has expired.

(5) If the Department or Rest Area Operator determines that the Acknowledgement Sign interferes with the maintenance, operation, or use of the Rest Area or the state highway, the sign will be removed. Acknowledgement Signs that are repeatedly vandalized or stolen may not be replaced at the discretion of the Rest Area Operator.

Stat. Auth.: ORS 184.616, 184.619, 366.205
Other Authority: Federal Policy 5160.1A
Stats. Implemented: ORS 366.205
Hist.: HWD 2-2016, f. & cert. ef. 6-21-16

734-031-0025
Acknowledgement Sign Design and Placement

(1) When an Acknowledgement Sign is used for sponsorship recognition on the mainline of the adjacent state highway or the Rest Area entrance or exit ramp, or is in a Rest Area and legible to motorists using the Rest Area, it must conform to the signing standards in the MUTCD and design standards adopted by the Department. Such Acknowledgement Signs must not have moving elements or simulate movement, have bold or vibrant colors, or be attached to, imitate or interfere with any traffic control device.

(2) When the sponsorship is for a specific Rest Area feature or a component of a specific Rest Area feature, one Acknowledgement Sign may be installed in the Rest Area placed at or as close as practical to the feature being sponsored. The sign will not be installed in a location where it would obscure a Rest Area visitor's view of traffic control devices, interfere with the regular use of the Rest Area by Rest Area visitors, or be visible from the mainline highway. The sign will say '_____ SPONSORED BY' on the first line and the Participant name or acronym on the next one or two lines.

(3) When the sponsorship is for the overall Rest Area, one Acknowledgement Sign for each direction of travel may be installed on the mainline upon approval of the Department. The Acknowledgement Sign may be an independent sign assembly or an acknowledgement plaque/rider added to an existing sign and placed as close as practicable to the entrance to the Rest Area and will say 'REST AREA SPONSORED BY' on the first line with the Participant name or acronym on the next one or two lines. Acknowledgement Signs on the mainline must be static, non-changeable signs and shall not be overhead installations. When the Acknowledgement Sign on the mainline is an independent sign assembly, it must be located at least 500 feet from any other traffic control device. In addition, one Acknowledgement Sign may be placed in the Rest Area provided the sign is not visible to the mainline highway and does not pose a safety risk to Rest Area users.

Stat. Auth.: ORS 184.616, 184.619, 366.205
Other Authority: Federal Policy 5160.1A
Stats. Implemented: ORS 366.205
Hist.: HWD 2-2016, f. & cert. ef. 6-21-16

734-031-0030
Sponsorship Agreement

(1) The Sponsorship Agreement shall be an agreement for the Participant to provide for development, operation or maintenance of a Rest Area. When the Sponsorship Agreement is for a Rest Area within Interstate highway right of way, the Sponsorship Agreement must be approved by Federal Highway Administration to determine consistency with its directives and MUTCD.

(2) The Sponsorship Agreement will include the name of the Rest Area and a full description of the Contribution including the quantity of Product being provided or the frequency that Highway Related Services are to be performed.

(3) The term of the Sponsorship Agreement will be for a period of at least 1 year.

(a) When the Contribution is a Highway Related Service for the Rest Area operation or maintenance, the service must be provided at least twice over the 1-year period. When the Highway Related Service is for development of a Rest Area or Rest Area feature, the Contribution must be for a significant portion of the overall project as identified in the project solicitation.

(b) When the Contribution is for a Product, the quantity of Product must be adequate to meet the expected need for the 1-year period.

(c) When the Contribution is money, the value must be a significant portion of the development cost or the cost to operate or maintain the Rest Area or the specific feature of the Rest Area.

(4) The Sponsorship Agreement is not transferable and may be cancelled by mutual consent of the parties or by the Rest Area Operator for cause including, but not limited to safety considerations concerning Rest Area or highway operations, failure of the Participant to perform the work described in the Sponsorship Agreement, failure of the Participant to comply with provisions of the Sponsorship Agreement, or a determination the sponsorship agreement is no longer in the public's best interest.

(5) The Participant shall not use the Rest Area or state highway to display advertising signs or display or sell merchandise of any kind. Unauthorized items may be removed at the direction of the Department, Rest Area Operator, or law enforcement personnel.

(6) The Participant shall be bound by all applicable federal, state and local laws, rules, and regulations and such other terms and conditions as may be required in the Sponsorship Agreement.

(7) When the Sponsorship Agreement is for a Highway Related Service, the Participant will have the following additional responsibilities:

(a) The Participant will be responsible and liable for the care, control, supervision and assurance of safety of all Participant members and the safety of Rest Area users.

(b) When work may impact motorists using the Rest Area or the mainline highway, the Participant will protect the work area in accordance with the MUTCD and the Oregon Temporary Traffic Control Handbook in force at the time the work is conducted.

(c) Maintain a copy of the fully signed Sponsorship Agreement at the worksite when the Highway Related Service is being performed and make it available to the Department, Rest Area Operator, or law enforcement personnel upon request. No work activities are to occur in the Rest Area until the Participant has obtained a fully signed Sponsorship Agreement.

(d) Vehicles used to transport Participant or its members to and from the Rest Area must be parked within the Rest Area so as not to interfere with the regular use of the Rest Area or to create a hazard to motor vehicle traffic. Vehicles must be moved by the Participant upon request of the Department, Rest Area Operator, or law enforcement personnel.

(e) The Participant must protect all existing Rest Area features, including but not limited to the paved surfaces, sidewalks, drainage features, landscaping, and fences, from damage as a result of their activity. The Participant shall restore any damaged feature to the satisfaction of the Rest Area Operator whether discovered at the time of damage or at a later date. Unrepaired damage or unrestored features may be repaired or restored by the Rest Area Operator at the expense of the Participant.

Stat. Auth.: ORS 184.616, 184.619, 366.205
Other Authority: Federal Policy 5160.1A
Stats. Implemented: ORS 366.205
Hist.: HWD 2-2016, f. & cert. ef. 6-21-16

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Employment Department
Chapter 471

Rule Caption: Definition of the Minimum Hourly Wage for the purposes of Unemployment Insurance
Adm. Order No.: ED 2-2016
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 471-030-0017
Subject: Amending the rule for "Defining and Allocating Remuneration, Holidays, and Vacations" to include a definition of "Hourly Minimum Wage". For the purposes of ORS 657.150(6)(a), the term "minimum hourly wage" means the minimum wage rate as identified in section (2) of Senate Bill 1532 (2016):

(2) If the employer is located within the urban growth boundary of a metropolitan service district organized under ORS chapter 268, except as provided by ORS 652.020 and the rules of the commissioner issued under ORS 653.030 and 653.261, for each hour of work time that the employee is gainfully employed, no employer shall employ or agree to employ any employee at wages computed at a rate lower than:

(a) From July 1, 2016, to June 30, 2017, $9.75.

(b) From July 1, 2017, to June 30, 2018, $11.25.

(c) From July 1, 2018, to June 30, 2019, $12.

(d) From July 1, 2019, to June 30, 2020, $12.50.

(e) From July 1, 2020, to June 30, 2021, $13.25.

(f) From July 1, 2021, to June 30, 2022, $14.

(g) From July 1, 2022, to June 30, 2023, $14.75.

(h) After June 30, 2023, an employer described in this subsection shall pay an employee no less than $1.25 per hour more than the minimum wage determined under subsection (1)(j) of this section.
Rules Coordinator: Cristina Koreski—(503) 947-1471

471-030-0017
Defining and Allocating Remuneration, Holidays, and Vacations

(1) Definitions. For purposes of applying ORS 657.100 and 657.150, and as used in this rule:

(a) "Employment" means:

(A) Being in an employer-employee relationship during a period of time for which remuneration was paid or payable; or

(B) Providing a service or product for cash or cash value.

(b) "Earnings" means remuneration;

(c) Where an employer-employee relationship exists, "remuneration" means compensation resulting from the employer-employee relationship, including wages, salaries, incentive pay, sick pay, compensatory pay, bonuses, commissions, stand-by pay, and tips;

(d) Where no employer-employee relationship exists, "remuneration" means the gross amount of compensation for the product or service, less only the value of tangible components involved in producing or providing the product or service and limited to the tangible components that remain with the party receiving the service or product;

(e) "Bonus" means an extra payment given by an employer in consideration of performance, production or a share of profits;

(f) "Back pay" means payment awarded as reimbursement by an employer for loss of wages during a period for which no services were performed and no payment was intended;

(g) For purposes of ORS 657.150(7), the term "holiday" means those holidays listed in 187.010(1)(b)–(j) and (2), 187.020 and any holiday designated by the employer, union contract or otherwise;

(h) For purposes of ORS 657.150(7), the term "vacation" means a specific period of time, paid or unpaid, during which the individual is freed from work/job/employment duties and responsibilities and is free to use the time away from work for any purpose the individual chooses.

(i) For purposes of ORS 657.150(6)(a), the term "minimum hourly wage" means the minimum wage rate as computed under 653.025(2).

(2) For purposes of section (1) of this rule, except for agricultural labor and domestic service, remuneration shall include the value, determined pursuant to OAR 471-031-0055(3), of compensation paid in any medium other than cash.

(3) Allocating Remuneration: For purposes of ORS 657.100 and 657.150(6) remuneration or an applicable pro-rata share thereof shall be allocated as follows:

(a) In the case of services, allocated to the week in which the service was performed;

(b) In the case of products, allocated to the week in which the product was sold;

(c) In the case of bonuses, allocated equally to the weeks during which the individual worked within the period being rewarded;

(d) If the dates of sale or service are not clearly established, allocation shall be made upon a reasonable estimate provided by the claimant. If the individual cannot or will not provide a reasonable estimate, the remuneration shall be allocated equally over the period during which services were rendered or products were sold.

(4) Back pay is not reportable for or deductible from unemployment insurance benefits.

Stat. Auth.: ORS 657
Stats. Implemented: ORS 657.100 & 657.150
Hist.: ED 8-2004, f. 12-17-04, cert. ef. 12-19-04; ED 3-2007, f. & cert. ef. 7-12-07; ED 2-2016, f. & cert. ef. 7-1-16

Mortuary and Cemetery Board
Chapter 830

Rule Caption: Relating to Temporary Operating Permit for a Cemetery that does not hold a valid license.
Adm. Order No.: MCB 1-2016(Temp)
Filed with Sec. of State: 7-6-2016
Certified to be Effective: 7-6-16 thru 1-1-17
Notice Publication Date:
Rules Amended: 830-011-0065
Subject: Permits State Mortuary and Cemetery Board to issue temporary permit to carry out existing prearrangement sales contracts to which cemetery is party and to effect rights of plot owners.
Rules Coordinator: Chad Dresselhaus—(971) 673-1503

830-011-0065
Temporary Burial Permit

(1) The Oregon Mortuary and Cemetery Board (Board) may grant a temporary burial permit authorizing interment in a cemetery that does not hold a current, valid license or registration for the sole purpose of facilitating an at-need burial in accordance with ORS 692.025, Sec. 1, and only when the normal procedures for licensing or registration of a cemetery authority cannot be completed before burial must take place.

(2) The burial permit request must be made on the most current application form provided by the Board and must include copies of all pre-qualifying pre-arrangement documents as well as evidence of the verification of plot location to be considered. A permit will not be granted when pre-arrangements or plot location cannot be produced or verified or when such documents are disputed.

(a) Applicants must be directly associated with the cemetery authority, with a licensed party to the pre-arrangements, or with another qualifying person in accordance with ORS 692.025, Sec. 1, and

(b) Must be working on behalf of person(s) requesting burial.

(c) The application must also include the specific details of the planned burial and evidence that it will be performed by persons qualified to do so, and

(d) All paperwork will be kept with the permit that was issued for the burial and filed at the OMCB with the copy of the permit until a permanent place can be decided upon. If the cemetery authority is not a party to the interment, the Board will maintain the records and provide to the appropriate party identified by the Board on the permit.

(3) Permit holder shall only be responsible for any issues related to the permitted interment and not for any pre-existing conditions, contract terms or document errors made by the Cemetery Authority, nor for the condition of and continuing maintenance of the plot after closing.

(4) Sections (1) and (2) shall be repealed on January 1, 2018.

Stat. Auth.: ORS 692.025
Stats. Implemented: ORS 692.025
Hist.: MCB 2-2015, f. 12-31-15, cert. ef. 1-1-16; MCB 1-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

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Oregon Department of Education, Early Learning Division
Chapter 414

Rule Caption: Rules for inspection of exempt family-home child care providers accepting federal subsidy.
Adm. Order No.: ELD 2-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 6-1-2016
Rules Adopted: 414-180-0005, 414-180-0010, 414-180-0015, 414-180-0020, 414-180-0025, 414-180-0030, 414-180-0035, 414-180-0040, 414-180-0045, 414-180-0050, 414-180-0055, 414-180-0090, 414-180-0100
Subject: The Child Care Development Block Grant Act of 2014 requires the Early Learning Division to begin annual health and safety inspections of license exempt Child Care providers who accept federal subsidies. ORS 329A.505 authorizes the Office of Child Care to conduct on-site inspections when such inspections are required under federal Law and authorizes the Office of Child Care to require improvements or corrections necessary to bring provider into compliance. The rules establish conditions and standards for compliance and sets forth the Early Learning Division's Office of Child Care (OCC) procedures and requirements for the inspection of exempt child care facilities subject to and in accordance with federal and state laws governing child care providers accepting subsidies.
Rules Coordinator: Lisa Pinheiro—(503) 910-8135

414-180-0005
Purpose

Oregon Administrative Rules (OAR) 414-180-0005 through 414-180-0100 are the Early Learning Division's minimum health and safety requirements for license exempt child care providers who accept federal child care subsidy payments through the state. The purpose of these rules is to protect the health, safety, and well-being of children in care. These rules apply to home based child care providers who accept federal child care subsidies from the Oregon Department of Human Services or the Early Learning Division Office of Child Care and are exempt from child care licensing as outlined in ORS 329A.250.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0010
Definitions

The following definitions apply to Oregon Administrative Rules 414-180-0015 through 414-180-0100.

(1) "Caregiver" means any person, including the provider, who cares for the children in Regulated Subsidy child care and works directly with the children, providing care, supervision and guidance.

(2) "Child Care" means the care, supervision and guidance on a regular basis of a child, unaccompanied by a parent, legal guardian or custodian, during a part of the 24 hours of the day, with or without compensation.

(3) "Child Care Child" means a child at least six weeks of age and under 13 years of age, or a child under 18 years of age with special needs. The provider has supervisory responsibility for the child in the temporary absence of the parent.

(4) "Child with Special Needs" means a child under 18 years of age who requires a level of care over and above the norm for their age due to a physical, developmental, behavioral, mental or medical disability.

(5) "Communicable Disease" means an illness caused by an infectious agent or its toxins.

(6) "Disinfecting" means using a process for destroying or irreversibly inactivating harmful organisms, including bacteria, viruses, germs and fungi.

(7) "Family" means a group of individuals related by blood, marriage or adoption, or individuals whose functional relationships are similar to those found in such associations.

(8) "Infant" means a child who is at least six weeks of age up to 12 months of age.

(9) "OCC" means the Office of Child Care, Early Learning Division of the Department of Education.

(10) "Outbreak of Communicable Disease" means two cases from separate households associated with a suspected common source.

(11) "Premises" means the structure where child care is conducted that is identified on the application or listed with the Department of Human Services, including indoors and outdoors and space not directly used for child care.

(12) "Preschool-Age Child" means a child who is 36 months of age up to eligible to attend kindergarten in a public school.

(13) "Provider" means the person or facility who is responsible for the children in care; is the children's primary caregiver; and who is listed with the Department of Human Services as the provider.

(14) "Regulated Subsidy Child Care" means care that is provided to children whose families access federal child care subsidy funds through the state.

(15) "Restrictable Disease" means an illness or infection that would prohibit the child from attending child care.

(16) "Sanitizing" means using a treatment that provides enough heat or concentration of chemicals for enough time to reduce the bacterial count, including disease producing organisms, to a safe level on utensils, equipment and toys.

(17) "Substitute Provider" means a person who acts as the child's primary caregiver in the temporary absence of the provider.

(18) "Toddler" means a child who is at least 12 months of age but is not preschool-age.

(19) "Useable Exit" means an unobstructed door or window through which the provider and the children can evacuate the home in case of a fire

or emergency. Doors must be able to be opened from the inside without a key.

(a) For homes built before July 1, 2010, window openings must be at least 20 inches wide and at least 22 inches in height, with a net clear opening of five square feet (at least 720 square inches) and a sill no more than 48 inches above the floor.

(b) For homes built after July 1, 2010, window openings must be at least 20 inches wide and at least 24 inches in height, with a net clear opening of five square feet (at least 720 square inches) and a sill no more than 44 inches above the floor.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0015
Health

(1) The child care home must be a healthy environment for children.

(2) There must be at least one flush toilet and one hand-washing sink available to children.

(3) The provider must comply with local, state and federal laws related to immunizations, child care restrictable diseases, child safety systems and seat belts in vehicles, bicycle safety, civil rights laws, and the Americans with Disabilities Act.

(4) Infants shall have a crib, portable crib or playpen with a clean, non-absorbent mattress. All cribs must comply with current Consumer Product Safety Commission (CPSC) standards. There shall be no items in the crib with the infant (e.g. toys, pillows or stuffed animals).

(5) If the parent(s) so request, siblings may share the same bed.

(6) The upper level of bunk beds shall not be used for children under ten years of age.

(7) If an infant uses a blanket, the blanket may not cover the infant's head or face.

(8) Infants must be laid on their backs on a flat surface for sleeping.

(9) Children shall not be laid down with a bottle for sleeping.

(10) First aid supplies and a chart or handbook of first aid instructions shall be maintained in one identified place and kept out of reach of children.

(11) The first aid supplies shall include: band aids, adhesive tape, sterile gauze pads, soap or sealed antiseptic towelettes or solution to be used as a wound cleaning agent, a solution for disinfecting after a blood spill, a sanitary temperature taking device.

(12) Illness:

(a) Except for mild cold symptoms that do not impair a child's daily functioning, sick children shall not be in care.

(b) A provider shall not admit or retain in care, except with the written approval of the local health office, a child who:

(A) Is diagnosed as having or being a carrier of a child care restrictable disease, as defined in Oregon Health Authority administrative rule; or

(B) Has one of the following symptoms or combination of symptoms or illness;

(i) Fever over 100°F, taken under the arm;

(ii) Diarrhea (more than one abnormally loose, runny, watery or bloody stool);

(iii) Vomiting;

(iv) Nausea;

(v) Severe cough;

(vi) Unusual yellow color to skin or eyes;

(vii) Skin or eye lesions or rashes that are severe, weeping, or pus-filled;

(viii) Stiff neck and headache with one or more of the symptoms listed above;

(ix) Difficult breathing or abnormal wheezing; or

(x) Complaints of severe pain.

(c) A child who, after being admitted into child care, shows signs of illness, as defined in this rule, whenever possible will be separated from the other children, and the parent(s) notified and asked to remove the child from the provider's home as soon as possible.

(d) If a child has mild cold symptoms that do not impair his/her normal functioning, the child may remain in the provider's home and the parent(s) notified when they pick up their child.

(13) Section 12 of this rule does not apply when the provider is caring only for children from the same family and no other unrelated child care children are present, except that the provider shall notify the parent if a child who, after being admitted into child care, shows signs of illness.

(14) Parents must be notified if their child is exposed to an outbreak of a communicable disease.

(15) No person shall smoke or carry any lighted smoking instrument, including an e-cigarette or vaporizer in the child care home or within ten feet of any entrance, exit, or window that opens or any ventilation intake that serves an enclosed area, during child care hours or when child care children are present.

(16) No person shall use smokeless tobacco in the child care home during child care hours or when child care children are present.

(17) No person shall smoke, carry any lighted smoking instrument, including an e-cigarette, or vaporizer or use smokeless tobacco in motor vehicles while child care children are passengers.

(18) No one shall consume alcohol on the child care home premises during child care hours or when child care children are present.

(19) No one shall be under the influence of alcohol on the child care home premises during child care hours or when child care children are present.

(20) No one shall possess, use or store illegal controlled substances on the child care home premises. No one shall be under the influence of illegal controlled substances on the child care home premises.

(21) No one shall grow or distribute marijuana on the premises of the child care home. No adults shall use marijuana on the child care home premises during child care hours or when child care children are present.

(22) Child care providers and any individual supervising, transporting, preparing meals, or otherwise working in the proximity of child care children and those completing daily attendance and billing records shall not be under the influence.

(23) "Under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the individual has used alcohol, any controlled substances (including lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana), or inhalants that impairs their performance of essential job function or creates a direct threat to child care children or others. Examples of abnormal behaviors include, but are not limited to hallucinations, paranoia, or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech as well as difficulty walking or performing job activities.

(24) All marijuana, marijuana derivatives and associated paraphernalia must be stored under child safety lock.

(25) Any animal at the provider's home shall be in good health and be a friendly companion for the children in care.

(26) Dogs and cats must be vaccinated according to a licensed veterinarian's recommendations.

(27) Dogs and cats shall be kept free of fleas, ticks and worms.

(28) Animal litter boxes shall not be located in areas accessible to children or areas used for food storage or preparation.

(29) Exotic animals, including, but not limited to: reptiles (e.g. lizards, turtles, snakes) amphibians, monkeys, hook-beaked birds, baby chicks and ferrets are prohibited unless they are housed in and remain in a tank or other container which precludes any direct contact by children. Educational programs that include prohibited animals and are run by zoos, museums and other professional animal handlers are permitted.

(30) Prescription and non-prescription medication shall only be given to a child if the provider has written authorization from the parent.

(31) Prescription and non-prescription medications must be properly labeled and stored.

(32) Non-prescription medications or topical substances must be labeled with the child's name.

(33) Prescription medications must be in the original container and labeled with the child's name, the name of the drug, dosage, directions for administering, and the physician's name.

(34) Medication requiring refrigeration must be kept in a separate, tightly covered container, marked "medication," in the refrigerator.

(35) Parents must be informed daily of any medications given to their child or any injuries their child has had.

(36) Sunscreen may be used with written parental authorization.

(a) In instances where parent has provided written permission to use sunscreen, providers must reapply sunscreen every two hours while the child care children are exposed to the sun.

(b) Providers shall use a sunscreen with an SPF of 15 or higher and must be labeled as "Broad Spectrum".

(c) Providers shall not use aerosol sunscreens on child care children.

(d) Sunscreen shall not be used on child care children younger than six months.

(37) Parents must be given the telephone number so they can contact the provider if needed.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0020
Sanitation

(1) Pre-mixed sanitizers and disinfectants that are EPA registered and meet Oregon Health Authority criteria may be used in all areas of the home per manufacturer instructions.

(2) All caregivers and children must wash their hands with soap and warm, running water:

(a) Before handling food;

(b) Before assisting with feeding;

(c) Before and after eating;

(d) After diapering;

(e) After using the toilet;

(f) After assisting someone with toileting;

(g) After nose wiping;

(h) After playing outside; and

(i) After touching an animal or handling pet toys.

(3) Hand sanitizers shall not replace hand washing. If hand sanitizers are present in the home, they shall be kept out of children's reach and shall not be used on children.

(4) Clean toys, equipment and furniture used by children when soiled.

(5) Diaper changing surfaces must be either:

(a) Non-absorbent and easily disinfected;

(b) Disposed of after each use; or

(c) Laundered after each use.

(6) The building, grounds, any toy, equipment, and furniture are maintained in a clean, sanitary, and hazard free condition.

(7) All garbage, solid waste, and refuse must be disposed of regularly, in a safe and sanitary manner.

(8) The home has safe drinking water.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0025
Safety

(1) The room temperature must be at least 68°F during the hours which child care children are in care.

(2) Rooms child care children are predominantly occupying must have a combination of natural and artificial lighting.

(3) Floors must be free of splinters, large unsealed cracks, sliding rugs and other hazards.

(4) Potentially aggressive animals must not be in the same physical space as the children.

(5) Children shall be protected from fire and safety hazards. Providers must have the following protections in place:

(a) All exposed electrical outlets in rooms used by preschool or younger children must have hard-to-remove protective caps or safety devices installed when the outlet is not in use.

(b) Extension cords shall not be used as permanent wiring;

(c) All appliance cords must be in good condition;

(d) Multiple connectors for cords shall not be used;

(e) A grounded power strip outlet with a built-in over-current protection may be used;

(f) A stable barrier shall be installed to prevent children from falling into hazards, including, but not limited to: fireplaces, heaters and woodstoves that are in use when child care children are present;

(g) A secure barrier shall be placed at the top and/or bottom of all stairways accessible to infants and toddlers;

(6) The home has a working smoke detector on each floor level and in any area where a child naps.

(7) Cleaning supplies, paints, matches, lighters, and any plastic bags large enough to fit over a child's head kept under child-safety lock.

(8) Other potentially dangerous items, such as medicine, drugs, sharp knives and poisonous and toxic materials kept under child-safety lock.

(9) Firearms, BB guns, pellet guns and ammunition kept under lock, with ammunition stored and locked separately. Firearms, BB guns and pellet guns must remain unloaded;

(10) If any preschool age or younger children are in care, poisonous plants must be kept out of the reach of children;

(11) All clear glass panels in doors clearly marked at child level.

(12) Each provider must:

(a) Ensure that the home where care is provided meets all of the following standards:

(A) Each floor level used by a child has two useable exits to the outdoors (a sliding door or window that can be used to evacuate a child is considered a useable exit). If a second floor is used for child care, the provider must have a written plan for evacuating occupants in the event of an emergency.

(B) The home has a working telephone or telephone service in operating condition.

(C) Emergency telephone numbers for fire, ambulance, police and poison control and the home address must be posted in a visible location.

(D) The building, grounds, water supply, and toys, equipment and furniture used by children must be maintained in a hazard-free condition.

(E) Broken toys, furniture and equipment must be removed from areas accessible to children.

(13) Wading pools are prohibited for wading.

(14) The provider is responsible for the children in care. At all times the provider must:

(a) Be within sight or sound of all children;

(b) Be aware of what each child is doing;

(c) Be near enough to children to respond when needed.

(15) The provider must have a written plan for evacuating and removing children to a safe location in an emergency. The plan must be posted in the child care home, familiar to the children and the caregivers, and practiced at least every other month and must include:

(a) Procedures for notifying parents or other adults responsible for the children, of the relocation;

(b) Procedures to address the needs of individual children, including those with special needs; and

(c) An acceptable method to ensure that all children in attendance are accounted for.

(16) If a caregiver is transporting children, the caregiver must have a valid driver's license and proof of appropriate insurance.

(17) The number of children transported shall not exceed the number of seat belts or child safety systems available in the vehicle.

(18) Car seats are to be used for transportation only. Children who arrive at and brought into the provider's home asleep in a car seat may remain in the car seat until the child awakens.

(19) The provider must take precautions to protect children from vehicular traffic.

(20) If a passenger van is used to transport child care children it must meet Federal Motor Vehicle Safety Standards for transporting children in education settings.

(21) The provider must have a written statement from the parent(s) regarding whether or not the provider is authorized to:

(a) Take a child on a field trip or other activity outside the child care home or participate in any water activity; and

(b) Transport a child to or from school or allow a child to bus or walk to or from school or child care home.

(22) 15-passenger vans shall not be used to transport child care children.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0030
Guidance and Discipline

(1) The following behaviors by caregivers are prohibited:

(a) Using any form of corporal punishment, including, but not limited to: hitting, spanking, slapping, beating, shaking, pinching or other measures that produce physical pain, or threatening to use any form of corporal punishment.

(b) Parental request or permission to use any form of behavior listed in subsection (a) of this section, does not give the provider or substitute provider permission to do so.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0035
Nutrition

(1) Meals and snacks must be based on the guidelines of the USDA Child and Adult Care Food Program.

(2) Foods must be stored and maintained at the proper temperature.

(3) Infants must be held or sitting up for bottle feeding. Propping bottles is prohibited.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0040
Access to Physical Activity

(1) Providers must make available activities, materials, and equipment for both indoor and outdoor play that provide a variety of experiences geared to the ages and abilities of the child(ren) with a balance of active and quiet play.

(2) Child care children shall not be exposed to more than two hours of screen time per day. All media exposure must be developmentally and age appropriate. Screen time is defined as time spent using a device such as a computer, television, or games console.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0045
Record Keeping

(1) The following records must be kept by the provider for at least one year and must be available at all times to OCC:

(a) Information from the parent(s) for each child at the time of admission:

(A) Name and birth date of the child;

(B) Any chronic health problem(s), including allergies, the child has;

(C) Date child entered care;

(D) Names, work and home telephone numbers and addresses, and the work hours of the parent(s) or legal guardian(s);

(E) Name and telephone number of person(s) to contact in an emergency;

(F) Name and telephone number of person(s) to whom the child may be released;

(G) Health history of any problems that could affect the child's participation in child care.

(b) Daily attendance records, including dates each child attended and arrival and departure times for each day. Times shall be recorded as the child care children arrive and depart.

(c) Medications administered, including the child's name, and the date and time of dosage and the dosage amount.

(d) Injuries to a child.

(2) Injuries to a child which require attention from a licensed health care professional, such as a physician, EMT or nurse, must be reported to OCC within seven days.

(3) The provider must have a written statement from the parent(s) regarding whether or not the provider is authorized to obtain emergency medical treatment for a child.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0050
General Requirements

(1) OCC records are open to the public on request. However, information protected by state or federal law will not be disclosed.

(2) The name and status of providers is public information.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0055
Enforcement of Regulatory Requirements

(1) The provider shall allow an inspection of all areas of the child care home that are accessible to child care children, and a health and safety review of other areas of the child care home to ensure the health and safety of child care children.

(2) The provider or substitute must allow a representative from the Office of Child Care access to the child care home any time child care children are present.

(3) The provider must allow parents or legal guardians of child care children access to the child care home during the hours their child(ren) are in care.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0090
Compliance with Child Abuse Reporting Requirements

Any caregiver who has reason to believe that any child has suffered or is currently suffering from abuse (physical injury, mental injury, neglect that leads to physical harm, sexual abuse and/or exploitation, or threat of harm) must report the information to the Department of Human Services Child Welfare (DHS) or to a law enforcement agency. By statute, this requirement applies 24 hours per day.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

414-180-0100
Exceptions to Rules

(1) A provider may request an exception to a rule.

(2) An exception must be requested on a form provided by OCC.

(3) The provider must provide a justification for the requested exception and an explanation of how the provider will ensure, through safeguards or other conditions, the health, safety and well-being of the children.

(4) The provider must be in compliance with the rule as written until the provider has received approval for the exception from OCC.

(5) No exception to a rule shall be granted unless the health, safety, and well-being of the children are ensured.

(6) An exception is valid only for the specified dates for which it is issued.

(7) The granting of an exception to a rule shall not set a precedent, and each request shall be evaluated on its own merits.

Stat. Auth.: ORS 326.425(7)
Stats. Implemented: ORS 329A.505
Hist.: ELD 2-2016, f. & cert. ef. 6-29-16

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Oregon Film and Video Office
Chapter 951

Rule Caption: Indigenous Oregon production investment fund production spending reimbursements
Adm. Order No.: FVO 1-2016
Filed with Sec. of State: 6-21-2016
Certified to be Effective: 6-21-16
Notice Publication Date: 6-1-2016
Rules Amended: 951-006-0000, 951-006-0001, 951-006-0005, 951-006-0010, 951-006-0020
Subject: Adds expense reimbursement for local filmmakers and local media production services companies to the iOPIF film & media incentive program as authorized by ORS 284.368(3) and adds crediting provisions.
Rules Coordinator: Nathan Cherrington—(971) 254-4020

951-006-0000
Purpose

The purpose of these rules is to provide guidance for the administration of the portion of the Oregon Production Investment Fund that is to be used for film and television production expense reimbursement for local filmmakers and local media production services companies as authorized by ORS 284.368(3).

Stat. Auth: ORS 284.335 & 284.368
Stats. Implemented: ORS 284.367 & 284.368
Hist.: FVO 2-2009, f. 11-12-09 cert. ef. 1-1-10; FVO 1-2016, f. & cert. ef. 6-21-16

951-006-0001
Definitions

(1) "Qualifying film or television production" means a movie produced for release to theaters, video or the Internet or a television movie or one or more episodes of a single television series, or a media production services project produced by a local media production services company, the production of which will result in the spending of at least $75,000.00 directly to Oregon resident vendors or for work done in Oregon. "Qualifying film or television production" does not include the production of a commercial or one or more segments of a newscast or sporting event.

(2) "iOPIF" means the part of the Oregon Production Investment Fund created by ORS 284.367 that is to be used to provide expense reimbursement for local film makers and local media production services companies pursuant to ORS 284.367(4).

(3) "Filmmaker" means a person who owns a television or film production company.

(4) "Local filmmaker" means a person who owns a television or film production company that has its principal place of business in this state.

(5) "Local media production services company" means a media production services company that has its principal place of business in this state.

(6) "Media production services" includes postproduction services and interactive video game development. "Media production services" does not

include the production of a commercial or one or more segments of a newscast or sporting event.

(7) "Media production services company" means a person who is engaged in media production services.

(8) "Resident of this state" has the meaning given that term in ORS 316.027.

(9) "OFVO" means the Oregon Film & Video Office created by ORS 284.305.

(10) "Principal place of business" means the office, in or out of this state, where the principal executive offices of a domestic or foreign corporation are located and where the company identifies as its singular "corporate headquarters."

Stat. Auth: ORS 284.335 & 284.368
Stats. Implemented: ORS 284.368
Hist.: FVO 2-2009, f. 11-12-09 cert. ef. 1-1-10; FVO 1-2016, f. & cert. ef. 6-21-16

951-006-0005
Program Application

A local filmmaker proposing to produce a qualifying film or television production or a local media production services company that wishes to receive reimbursement for production spending from the iOPIF with respect to the production shall submit an application to the OFVO for an eligibility determination. Unless otherwise permitted by the OFVO, the application must be submitted prior to the commencement of production. Incomplete applications will not be accepted.

Stat. Auth: ORS 284.335 & 284.368
Stats. Implemented: ORS 284.368
Hist.: FVO 2-2009, f. 11-12-09 cert. ef. 1-1-10; FVO 1-2016, f. & cert. ef. 6-21-16

951-006-0010
Eligibility Determination

(1) Except as set forth in sections (2) and (3), the OFVO will approve the applications for eligibility for productions that satisfy the following requirements:

(a) The production satisfies the non-monetary portions of the "qualifying film or television production" definition.

(b) Projected spending in Oregon on the production is reasonably anticipated to equal not less than $75,000.

(c) The local filmmaker or local media production services company includes, with its application, a letter to the OFVO stating its intent for production to take place in Oregon and its willingness and ability to enter into a contract with the OFVO setting forth the terms and conditions of reimbursement.

(d) Upon request of the OFVO, provide proof of production insurance. The example below shows industry standards for an average live action film/television production. Varying coverage amounts may be approved by the OFVO based on industry standards for the specific type of project for which the reimbursement is requested.

REQUIRED:
General Liability
General Liability aggregate — $1,000,000
GL Limit Per Occurrence — $1,000,000
Products Completed Operations — $1,000,000
Personal & Advertising Injury — $1,000,000
Fire Legal Liability — $50,000
Medical Payments — $5,000
Blanket Additional Insured's — $ included
Waiver of Subrogation — $ included
Automobile
Hired & Non-Owned Liability — $1,000,000
Hired/Non-Owned Physical Damage — $500,000
Third Party Property Damage — $500,000
Worker's Compensation (OR State Minimums)
Bodily Injury by Accident — $500,000 Each Accident
Bodily Injury by Disease — $500,000 Policy Limit
Bodily Injury by Disease — $500,000 Each Employee
RECOMMENDED:
Negative Film or Videotape — Included
Faulty Stock, Camera & Processing: Included
Extra Expense — $25,000
Civil Authority — $25,000

(e) Name and contact information for payroll company.

(2) The following productions are not eligible:

(a) A production of a local filmmaker or local media production services company that has, or whose principals have, a verifiable history of previous production problems that create significant doubt, as determined by the OFVO, regarding the ability of the local filmmaker or local media production services company to complete a production in Oregon successfully. The production problems may include, but are but not limited to:

(A) unpaid financial obligations;

(B) crew mistreatment; or

(C) damage to locations that the local filmmaker or local media production services company did not repair upon completion of the production.

(b) A production with respect to which the local filmmaker or local media production services company withdraws its application for eligibility determination.

(c) A production that the OFVO determines is unlikely to further the purposes of the iOPIF.

(d) The production must pay its employees minimum wage as set forth in the Oregon minimum wage rule (ORS653.025) or meet the requirements of applicable union contracts the production has entered into.

(e) A production that employs any individual as an "intern" without that individual receiving academic credit. See the Oregon Bureau of Labor and Industries for additional information: www.boli.state.or.us/BOLI/TA/T_FAQ_Interns.shtml. A production determined to be ineligible may appeal to the Film and Video Board, upon written application.

(3) If the OFVO receives multiple relatively concurrent applications for eligibility determinations and there are not sufficient funds available in the iOPIF to pay the requested expense reimbursements with respect to all of the productions, the OFVO will determine which applications to approve and which to deny based on the following factors:

(a) satisfaction of requirements of section (1)

(b) chronological order of receipt of application

(c) amount of production spending anticipated in Oregon

(d) number of production workers expected to be hired

(e) experience level of local filmmaker or local media production services company

(f) reputation of the local filmmaker or local media production services company and its principals

(g) estimated production start date

(h) other benefits to Oregon, including but not limited to promotional value, long-term financial benefits, contribution to development of Oregon's crew and talent base or production industry infrastructure.

(i) Whether the local filmmaker or local media production services company has contributed to the iOPIF.

(j) Whether the local filmmaker or local media production services company intends to pay prevailing industry rates and provide health, retirement and other benefits.

(4) Upon approval of an application for eligibility with respect to a production, the local filmmaker or local media production services company must enter into a contract with OFVO stipulating its intent to make the production in Oregon and setting forth the terms and conditions of the reimbursement. If the local filmmaker or local media production services company and the OFVO have not entered into the contract within 30 days of its eligibility approval, the local filmmaker or local media production services company's eligibility will be automatically revoked unless the OFVO, in its discretion, extends the deadline for contract execution.

Stat. Auth: ORS 284.335 & 284.368
Stats. Implemented: ORS 284.368
Hist.: FVO 2-2009, f. 11-12-09 cert. ef. 1-1-10; FVO 1-2016, f. & cert. ef. 6-21-16

951-006-0020
Payment of Rebates

(1) Regardless of whether the production is otherwise a qualifying film or television production or a qualified local media production or whether the OFVO determined the production eligible, reimbursement of expenses from the iOPIF will only be paid pursuant to and upon the terms and conditions of a contract entered into between the OFVO and the local filmmaker or local media production services company pursuant to OAR 951-006-0010(4). If the local filmmaker or local media production services company does not enter into a contract with OFVO, the local filmmaker or local media production services company will not receive any reimbursement of expenses from OFVO.

(2) In addition to any other terms and conditions that the OFVO considers necessary or desirable, contracts for iOPIF reimbursements will usually include the following provisions:

(a) The local filmmaker or local media production services company must submit to the OFVO, after completion of the production work in Oregon, financial and other records sufficient to verify that the production satisfied the expenditure requirement for reimbursement.

(b) Authorization for the OFVO to deduct from the reimbursement the costs reasonably incurred by the OFVO in verifying the production expenditures in Oregon, including but not limited to, the costs incurred by OFVO in obtaining an outside accounting review, audit, or both, of the financial and other records evidencing the expenditures. The OFVO will usually sub-

mit the expenditure documentation to an outside accounting firm for a review after the OFVO has completed its review. Based on the advice of the outside accounting firm, the OFVO may require an audit of the production's financial records.

(c) OFVO's obligation to make any reimbursement of expenses is conditioned on (i) availability of funds in the iOPIF to pay for the requested reimbursement and (ii) compliance by the local filmmaker or local media production services company with the terms of the contract and satisfactory verification of production spending in Oregon of at least US $75,000.

(d) The local filmmaker or local media production services company must provide to OFVO vendor lists with final accounting.

(e) The local filmmaker or local media production services company must provide promotional materials (such as photos, trailers, and electronic press kits) to OFVO. OFVO may use such materials strictly for its own archival, governmental relations and marketing purposes. OFVO shall not grant usage to any other entity or charge for any such usage and shall request additional permission prior to any use other than those listed. OFVO understands that talent contracts may prohibit use of actors' images without express permission and agrees to abide by such limitations when advised in writing of said limitations.

(f) A minimum of 80 percent of the production's employees and independent contractors must be residents of Oregon. Background performers may not be counted toward meeting this requirement.

(g) The local filmmaker or local media production services company must provide the final crew list along with proof of residency for each crew member. Proof of residency may include an Oregon driver's license, or other legal documents approved by the Director of the OFVO, or may be provided through a payroll report that shows state of residency.

(h) The local filmmaker or local media production services company must employ or contract with a public accountant certified under ORS 673.040 for the provision of payroll services.

(i) The local filmmaker or local media production services company must provide OFVO proof of completion of the production in the form of a rough cut of the film/television/media production, or submission of a selection of dailies, either of which will demonstrate original script synopsis. Other proof of completion is subject to approval of the OFVO.

(j) The local filmmaker or local media production services company must provide a list, if utilized, of interns and the academic institutions, including contact information, from which such interns are receiving academic credit.

(k) Productions receiving rebates will include the approved "Oregon Film" logo and/or the "Oregon Made" logo in the final end crawl or packaging of the project wherever allowed by Filmmaker's contracts with its clients.

(3) Payment of iOPIF reimbursements are subject to funds being available for the iOPIF program.

Stat. Auth: ORS 284.335 & 284.368
Stats. Implemented: ORS 284.368
Hist.: FVO 2-2009, f. 11-12-09 cert. ef. 1-1-10; FVO 1-2016, f. & cert. ef. 6-21-16

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Oregon Health Authority, Health Licensing Office
Chapter 331

Rule Caption: Individuals seeking Board of Athletic Trainer renewals can attest to having current CPR certification.
Adm. Order No.: HLO 1-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 331-130-0011
Subject: Individuals seeking renewal of certification from the Board of Athletic Trainers can attest to having current cardiopulmonary resuscitation certification.
Rules Coordinator: Samantha Patnode—(503) 373-1917

331-130-0011
Registration Issuance and Renewal

(1) REGISTRATION: A registrant is subject to the provisions of OAR chapter 331, division 30 regarding the issuance and renewal of a registration, and to provisions regarding authorization to practice, identification, and requirements for issuance of a duplicate registration.

(2) LICENSE RENEWAL: Registration renewal must be made prior to the registration entering inactive status. The registrant must submit the following:

(a) Renewal application form;

(b) Payment of required renewal fee;

(c) Attest to having obtained required continuing education; and

(d) Attest to having current certification in cardiopulmonary resuscitation pursuant to OAR 331-130-0001.

(3) INACTIVE REGISTRATION RENEWAL: Registration renewal made after the registration enters inactive status. A registration may be inactive for up to three years. To renew inactive registration, the registrant must submit the following:

(a) Renewal application form;

(b) Payment of delinquency and renewal fees pursuant to OAR 331-140-0000;

(c) Attest to having obtained required continuing education; and

(d) Attest to having current certification in cardiopulmonary resuscitation pursuant to OAR 331-130-0001.

(4) EXPIRED REGISTRATION: A registration that has been inactive for more than three years is expired and must meet the requirements listed in OAR 331-130-0001.

(5) A registrant failing to meet continuing education requirements listed under OAR 331-150-0005 must reapply and meet requirements pursuant to OAR 331-130-0001.

(6) A registrant may not practice with an inactive or expired registration.

Stat. Auth.: ORS 676.615, 688.709, 688.715,
Stats. Implemented: ORS 688.715, 688.718, 688.720
Hist.: HLA 12-2012, f. 8-16-12, cert. ef. 8-17-12; HLO 1-2016, f. 6-28-16, cert. ef. 7-1-16

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Rule Caption: Require practitioners complete an OHA survey in accordance with 2015 Legislation SB 230.
Adm. Order No.: HLO 2-2016
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Amended: 331-715-0010
Subject: During the 2015 Legislative Session SB 230 was enacted adding respiratory therapists and polysomnographic technologists to the list of health care professionals who must provide certain demographic and practice information prescribed by Oregon Health Authority (OHA) in order to renew their license.

SB 230 specifies the type of information that may be collected including but not limited to demographics, education, training, employment information and specialty practice information. Other health care professionals, including licensed dietitians, who are required to provide this information pay a $2 annually which is collected at time of renewal
Rules Coordinator: Samantha Patnode—(503) 373-1917

331-715-0010
License Issuance and 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 331-705-0060;

(c) Attestation of having obtained required biannual continuing education under OAR 331-720-0010 or 331-720-0015, on a form prescribed by the Agency, whether license is current or inactive; and

(d) Attest to having provided the required information to the Oregon Health Authority pursuant to ORS 676.410;

(e) Pay fee established by Oregon Health Authority pursuant to ORS 676.410; and

(f) Information, on a form prescribed by the Agency, permitting the Agency to perform a state criminal background check pursuant to OAR 331-030-0004;

(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 331-705-0060;

(c) Attestation of having obtained required biannual continuing education under OAR 331-720-0010 or 331-720-0015, on a form prescribed by the Agency, whether license is current or inactive;

(d) Attest to having provided the required information to the Oregon Health Authority pursuant to ORS 676.410;

(e) Pay fee established by Oregon Health Authority pursuant to ORS 676.410; and

(f) Information, on a form prescribed by the Agency, permitting the Agency to perform a state criminal background check pursuant to OAR 331-030-0004;

(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 331-710-0010 or 331-710-0050.

(6) A licensee failing to meet continuing education requirements listed under OAR 331-720-0010 or 331-720-0015 is considered to have an expired license and must reapply and meet requirements pursuant to OAR 331-710-0010 or 331-710-0050.

Stat. Auth.: ORS 676.605, 676.615 & 688.830

Stats. Implemented: ORS 676.605, 676.615 & 688.830

Hist.: HDLB 1-1997(Temp), f. 12-19-97, cert. ef. 12-22-97 thru 6-19-98; HDLP 1-1998(Temp), f. & cert. ef. 3-20-98 thru 4-1-98; HDLP 2-1998, f. & cert. ef. 6-15-98; HLO 4-2004, f. 6-29-04, cert. ef. 7-1-04; HLO 10-2004(Temp), f. & cert. ef. 11-8-04 thru 3-31-05; HLO 1-2005, f. 2-28-05 cert. ef. 3-1-05; HLA 7-2010, f. & cert. ef. 11-1-10; HLA 15-2011, f. 12-30-11, cert. ef. 1-1-12; HLO 2-2016, f. & cert. ef. 7-1-16

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Oregon Health Authority, Health Licensing Office, Board of Certified Advanced Estheticians
Chapter 819

Rule Caption: Enact rules to certify advanced estheticians and comply with the requirements of HB 2642.

Adm. Order No.: BCAE 1-2016(Temp)

Filed with Sec. of State: 7-1-2016

Certified to be Effective: 7-1-16 thru 12-27-16

Notice Publication Date:

Rules Adopted: 819-005-0000, 819-020-0030, 819-020-0040, 819-020-0050, 819-020-0060, 819-020-0070, 819-020-0080, 819-040-0000

Subject: During the 2015 Legislative Session, House Bill 2642 was enacted, which created the Board of Certified Advanced Estheticians (Board) in Oregon. The purpose of the Board is to oversee and regulate the practice of advanced nonablative esthetics, including the use of lasers and other devices registered with the U.S. Food and Drug Administration. However, according to the bill, the Board does not have the authority to begin meeting or making decisions until July 1, 2016.

As of July 1, 2016 the Health Licensing Office (HLO) must begin issuing certificates to practice non ablative esthetics. Since this is a newly regulated profession there has been little standardized training available to individuals. The legislature contemplated these facts and provided provisions for grandfathering individuals into the profession until December 31, 2017.

In order to establish requirements by July 1, 2016, HLO is filing temporary administrative rules creating a provisional certification with supervision for individuals who need some or all the education training requested under the grandfathering provisions. Education and training requirements are 40 hours of theory and fundamentals and 24 hours in each of the following modalities: skin rejuvenation, photo rejuvenation, body contouring, dyschromia reduction, cellulite reduction, hair removal or reduction, and nonablative tattoo removal.

For individuals who obtained the required training prior to July 1, 2016 or who have worked at least 500 hours under a health care professional whose scope of practice includes non ablative esthetics a temporary certification has been created which does not require supervision.

The legislature approved fees during the 2015 Legislative Session which have been added to the fee schedule within the rule.

Rules Coordinator: Samantha Patnode—(503) 373-1917

819-005-0000
Definitions

As used in OAR 819-005-0000 to 819-040-0000:

(1) "Applicant" means a natural person applying to be certified as a "certified advanced esthetician" as that term is defined in ORS 676.630(2).

(2) "Board" means the Board of Certified Advanced Estheticians.

(3) "Modality" means

(a) Skin rejuvenation;

(b) Photo rejuvenation;

(c) Body contouring;

(d) Dyschromia reduction;

(e) Cellulite reduction;

(f) Hair removal or reduction; and

(g) Nonablative tattoo removal.

(4) "Office" means Health Licensing Office.

(5) "Provisional certificate" means an authorization to perform advanced nonablative esthetics procedures as defined in ORS 676.630(1) under supervision for purposes related to education or training.

(6) "Temporary certificate" means an authorization to practice advanced nonablative esthetics for a limited time.

Stat. Auth.: ORS 676.586, 676.615, 6786.630, 676.655, 2015 OL Ch. 722

Stats. Implemented: ORS 676.586, 6786.630, 676.655, 2015 OL Ch. 722

Hist.: BCAE 1-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

819-020-0030
Advanced Esthetician Temporary Certification

(1) A temporary certification authorizes the holder to temporarily practice advanced nonablative esthetics while waiting to pass the Board-approved qualifying examination required under ORS 676.640

(2) A temporary certification is valid through December 31, 2017 or until a permanent certificate is obtained.

Stat. Auth.: ORS 676.586, 676.615, 6786.630, 676.655, 2015 OL Ch. 722

Stats. Implemented: ORS 676.586, 6786.630, 676.655, 2015 OL Ch. 722

Hist.: BCAE 1-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

819-020-0040
Application Requirements for Temporary Certification

An applicant for a temporary certificate must:

(1) Comply with the requirements of OAR chapter 331 division 30;

(2) Submit a completed application form prescribed by the Office, containing the information listed in OAR 331-030-0000, and payment of all required fees;

(3) Be at least 18 years of age. Applicant must provide to Office official documentation confirming date of birth, such as a copy of the applicant's birth certificate, driver's license, or passport;

(4) Hold an active esthetic certificate through the Oregon Board of Cosmetology pursuant to ORS 690.046-690.047 and be in good standing with no current or pending disciplinary action;

(5) Provide name, license number and address of the Oregon Board of Cosmetology facility listed under ORS 690.005 where advanced nonablative esthetics procedures are performed by the applicant, pursuant to ORS 676.655(2)(a);

(6) Attest to maintaining client disclosure forms that include, at minimum, disclosure of the existence of professional liability insurance, pursuant to ORS 676.655(2)(b)

(7) Submit information identifying the individual with whom the applicant has entered into a collaborative agreement pursuant to ORS 676.655(2)(c). The collaborative agreement must be with one of the following health care professional who holds an active license in good standing with no current or pending disciplinary action:

(a) Physician licensed under ORS Chapter 677;

(b) Nurse practitioner licensed under ORS 678.375 to 678.390;

(c) Dentist licensed under ORS 679 who works at the same location as the certified advanced esthetician and who has the authority to prescribe drugs listed in Schedule III, IV or V; OR

(d) Naturopathic physician licensed under ORS 685 who works at the same location as the certified advanced esthetician and who has the authority to prescribe drugs listed in Schedule III, IV or V.

(8) Submit documentation of qualification for certification through one of the following pathways:

(a) Pathway One: 500 Supervised Hours of Experience — An applicant under pathway one must:

(A) Submit documentation to the Office showing proof of employment for at least 500 hours as a laser operator under the supervision of one of the following licensed health care professionals whose scope of practice includes the practice of advanced nonablative esthetics procedures and whose license is in good standing with no current or pending disciplinary action with the health care professional's respective regulatory body:

(i) A physician licensed under ORS chapter 677;

(ii) A nurse practitioner licensed under ORS 678.375 to 678.390;

(iii) A dentist licensed under ORS 679;

(iv) A naturopathic physician licensed under ORS 685; OR

(b) Pathway Two: 168 Hours of Experience and 40 Hours of Education — An applicant under pathway two must:

(A) Submit documentation showing completion of forty hours of education related to laser theory and fundamentals and twenty-four hours of practical experience in each modality defined under OAR 819-005-0000. Documentation may include but is not limited to manufacturer training certificates, educational transcripts, supervision records signed by a supervisor, employment records and client records.

Stat. Auth.: ORS 676.586, 676.615, 6786.630, 676.655, 2015 OL Ch. 722
Stats. Implemented: ORS 676.586, 6786.630, 676.655, 2015 OL Ch. 722
Hist.: BCAE 1-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

819-020-0050
Advanced Esthetician Provisional Certification — Education and Training

(1) A provisional certification authorizes the holder to practice advanced nonablative esthetics under supervision for the purpose of education and training for each modality defined to OAR 819-005-0000 and in laser theory and fundamentals.

(2) A provisional certification is valid through December 31, 2017 or until a temporary or permanent certificate is obtained.

Stat. Auth.: ORS 676.586, 676.615, 6786.630, 676.655, 2015 OL Ch. 722
Stats. Implemented: ORS 676.586, 6786.630, 676.655, 2015 OL Ch. 722
Hist.: BCAE 1-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

819-020-0060
Application Requirements for Provisional Certification — Education and Training

An applicant for a provisional certificate must:

(1) Comply with the requirements of OAR chapter 331 division 30;

(2) Submit a completed application form prescribed by the Office, containing the information listed in OAR 331-030-0000, and pay all required fees;

(3) Be at least 18 years of age. Applicant must provide to the Office official documentation confirming date of birth, such as a copy of the applicant's birth certificate, driver's license, or passport;

(4) Hold an active esthetic certificate through the Oregon Board of Cosmetology pursuant to ORS 690.046-690.047 and be in good standing with no current or pending disciplinary action;

(5) Submit information identifying the applicant's proposed supervisor. The proposed supervisor must meet the requirements listed under OAR 819-020-0070(1)(a) or (b);

(6) Provide name, license number and address of the Oregon Board of Cosmetology facility listed under ORS 690.005 where advanced nonablative esthetics procedures are performed by the applicant pursuant to ORS 676.655(2)(a);

(7) Attest to maintaining client disclosure forms that include, but are not limited to, at minimum, disclosure of the existence of professional liability insurance pursuant to ORS 676.655(2)(b)

(8) Submit information identifying the individual with whom the applicant has entered into a collaborative agreement pursuant to ORS 676.655(2)(c). The collaborative agreement must be with one of the following health care professional who holds an active license in good standing with no current or pending disciplinary action:

(a) Physician licensed under ORS Chapter 677;

(b) Nurse practitioner licensed under ORS 678.375 to 678.390;

(c) Dentist licensed under ORS 679 who works at the same location as the certified advanced esthetician and who has the authority to prescribe drugs listed in Schedule III, IV or V; OR

(d) Naturopathic physician licensed under ORS 685 who works at the same location as the certified advanced esthetician and who has the authority to prescribe drugs listed in Schedule III, IV or V.

Stat. Auth.: ORS 676.586, 676.615, 6786.630, 676.655, 2015 OL Ch. 722
Stats. Implemented: ORS 676.586, 6786.630, 676.655, 2015 OL Ch. 722
Hist.: BCAE 1-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

819-020-0070
Supervisor Approval and Requirements

(1) To be approved as a supervisor of a provisional certificate holder, an individual must:

(a) Hold an active license as a physician under ORS Chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390, a dentist licensed under ORS 679, a or naturopathic physician licensed under ORS 685, and whose scope of practice includes the practice of advanced nonablative esthetic procedures. The supervisor must have no current or pending disciplinary action with a regulatory body; and

(A) Attest to practicing advanced nonablative esthetics for at least three years prior to the date of application in the modality in which they will be supervising the provisional certificate holder; OR

(b) Hold an active esthetic certificate through the Oregon Board of Cosmetology pursuant to ORS 690.046-690.047 and be in good standing with no current or pending disciplinary action;

(A) Hold an active permanent or temporary advanced nonablative esthetics certification under ORS 676.630 to 676.660 through the Board of Certified Advanced Estheticians with no current or pending disciplinary action with the Office;

(B) Attest to practicing advanced nonablative esthetics for at least three years prior to the date of application in the modality for which they will be supervising the provisional certificate holder.

(2) For each modality, the supervisor must do, at a minimum, (a)–(c):

(a) Directly supervise the provisional certificate holder for at least the first ten hours of supervision. Direct supervision means the supervisor is present in the facility and actively involved in direct oversight and training including allowing the provisional certificate holder to assist in the procedure;

(b) Indirectly supervise the provisional certificate holder for at least the next fourteen hours of procedures. Indirect supervision is being available for direct consultation in person or from offsite including but not limited to phone or video conferencing; and

(c) Upon completion of the above twenty-four hours listed in (a) through (b) of this rule in a modality, or additional hours if required by a supervisor under (6), the provisional certificate holder must meet with the supervisor in that modality at least once every 30 days to discuss the provisional certificate holder's procedures and questions, and provide information on contraindications and appropriate referrals or consultations.

(d) At the option of the supervisor if the provisional certificate holder has obtained at least twenty-four hours of practical experience in the modality the supervisor is supervising

(3) The supervisor must have the provisional certificate holder obtain at least forty hours of education in laser theory and fundamentals listed in the 2011 American National Standard Z136.1 and American National Standards Laser Safety Education Program Z136.3. The education must include the following topics:

(a) The Laser

(A) Physics and biological effects

(B) Dosimetry and beam parameters

(C) Components of the laser system, delivery devices, and instrumentation

(D) Overview of clinical applications

(b) Administrative Controls

(A) Laser committee

(B) Role of the LSO, DLSO, LSSC

(C) Development of policies and procedures

(D) Documentation methods

(E) Regulations, standards and recommended professional practices

(F) Certification criteria and skills validation

(c) Procedural Controls

(A) Controlled access

(B) Eye protection

(C) Reflection hazards

(D) Flammability hazards and draping

(E) Electrical safety

(F) Management of plume

(G) Equipment testing, aligning, and troubleshooting

(4) A supervisor must exercise management, guidance, and control over the activities of the provisional certificate holder and must use reasonable professional judgment when supervising. A supervisor is responsible for all matters related to the provisional certificate holder's advanced nonablative esthetics procedures.

(5) A supervisor must document the provisional certificate holder's education and training on a form prescribed by the Office.

(6) A supervisor must provide the supervision described under subsection (2) of this rule in the modality in which they are supervising for the duration of time the individual holds a provisional certificate.

(7) If the supervisor determines the provisional certificate holder needs further direct or indirect supervision, the supervisory may require hours in addition to what is described under subsection (2) of this rule

(8) The supervisor may require supervision in addition to what is described under subsection (2) of this rule.

(9) A supervisor must notify the Office in writing within 10 calendar days if a provisional certificate holder is no longer being supervised, and must provide the number of hours of education and training the provisional certificate holder completed on a form prescribed by the Office.

(10) The Office may withdraw its approval of a supervisor if the supervisor provides incomplete or inadequate education or training during supervision, provides incompetent or negligent education or training, as those terms are defined in OAR 331-020-0070, fails to exercise management, guidance, and control over the activities of the provisional certificate holder, fails to exercise reasonable professional judgment when supervising, is disciplined by the supervisor's licensing board, or falsifies documentation.

Stat. Auth.: ORS 676.586, 676.615, 6786.630, 676.655, 2015 OL Ch. 722
Stats. Implemented: ORS 676.586, 6786.630, 676.655, 2015 OL Ch. 722
Hist.: BCAE 1-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

819-020-0080
Requirements for a Provisional Certificate Holder

(1) For each modality, the provisional certificate holder must:

(a) For at least the first ten hours of supervision, the provisional certificate holder must assist the supervisor performing procedures in a modality under the supervisor's direct supervision as described under OAR 819-020-0070;

(b) For at least the next fourteen hours of supervision, the provisional certificate holder must perform services under the supervisor's indirect supervision, as described under OAR 819-020-0070.

(c) Upon completion of the above twenty-four hours in a modality listed in (a) and (b) of this rule, or additional hours if required by a supervisor or additional hours if required by a supervisor. The provisional certificate holder must meet with the supervisor in that modality at least once every 30 days to discuss the provisional certificate holder's procedures and questions, and provide information on contraindications and appropriate referrals or consultations.

(2) The provisional certificate holder must obtain at least forty hours of education in laser theory and fundamentals listed in the 2011 American National Standard Z136.1 and American National Standards Laser Safety Education Program Z136.3. The education must include the following topics:

(a) The Laser:

(A) Physics and biological effects;

(B) Dosimetry and beam parameters;

(C) Components of the laser system, delivery devices, and instrumentation;

(D) Overview of clinical applications.

(b) Administrative Controls:

(A) Laser committee;

(B) Role of the LSO, DLSO, LSSC;

(C) Development of policies and procedures;

(D) Documentation methods;

(E) Regulations, standards and recommended professional practices;

(F) Certification criteria and skills validation.

(c) Procedural Controls:

(A) Controlled access;

(B) Eye protection;

(C) Reflection hazards;

(D) Flammability hazards and draping;

(E) Electrical safety;

(F) Management of plume;

(G) Equipment testing, aligning, and troubleshooting.

(3) A provisional certificate holder must notify the Office within 10 calendar days of changing a supervisor or obtaining an additional supervisor.

(4) A provisional certificate holder is prohibited from practicing in a modality until the supervisor, having experience in that modality, is approved by the Office.

Stat. Auth.: ORS 676.586, 676.615, 6786.630, 676.655, 2015 OL Ch. 722
Stats. Implemented: ORS 676.586, 6786.630, 676.655, 2015 OL Ch. 722
Hist.: BCAE 1-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

819-040-0000
Fees

(1) An applicant or authorization holder is subject to provisions of OAR 331-010-0010 and 331-010-0020 regarding payment of fees, penalties and charges.

(2) Fees established by the Health Licensing Office, are as follows:

(a) Application for Provisional Certification: $100

(b) Original Provisional Certification: $100

(c) Application for Temporary Certification: $100.

(d) Original Temporary Certification: $100

(3) An applicant applying for a temporary certification who previously held a provisional certification may be granted a $100 certification fee discount through January 1, 2018. The certification fee discount is available to individuals who meet all application requirements for a temporary advanced esthetic certification under OAR 819-020-0040 and reside in Oregon. An application fee of $100 for temporary certification must be paid in order to be granted the $100 certification fee discount.

Stat. Auth.: ORS 676.586, 676.615, 6786.630, 676.655, 2015 OL Ch. 722
Stats. Implemented: ORS 676.586, 6786.630, 676.655, 2015 OL Ch. 722
Hist.: BCAE 1-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

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Oregon Health Authority, Health Policy and Analytics
Chapter 409

Rule Caption: Amendments to the All Payer All Claims data reporting program rules.
Adm. Order No.: OHP 10-2016
Filed with Sec. of State: 6-22-2016
Certified to be Effective: 1-1-17
Notice Publication Date: 6-1-2016
Rules Amended: 409-025-0100, 409-025-0110, 409-025-0120, 409-025-0130, 409-025-0150
Subject: The Oregon Health Authority is amending these rules in order to update language and align data collection requirements with program needs, OHA priorities, and statutory requirements. The Authority is adding two new required appendices. Appendix G captures every Billing Provider or Organization with a place of business in Oregon, and account for all primary care and non-primary care related dollars disbursed to each of them by the type of payment arrangements in place. Appendix H collects summary data pertaining to Appendix G, such as record counts, which will be used to confirm that the data file is received and loaded correctly.
Rules Coordinator: Zarie Haverkate—(503) 931-6420

409-025-0100
Definitions

The following definitions apply to OAR 409-025-0100 to 409-025-0170:

(1) "Accident policy" means an insurance policy that provides benefits only for a loss due to accidental bodily injury.

(2) "Allowed amount" means the actual amount of charges for healthcare services, equipment, or supplies that are covered expenses under the terms of an insurance policy or health benefits plan.

(3) "Annual supplemental provider level APM summary file" means a data set composed of total and primary care-related dollars disbursed, by payment arrangement and line of business, to billing providers and organizations with a place of business in Oregon.

(4) "APAC" means all payer all claims.

(5) "APM" means alternative payment method.

(6) "Association" means any organization, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and that has been organized and is maintained in good faith primarily for purposes other than that of obtaining insurance.

(7) "Attending provider" means the individual health care provider who delivered the health care services, equipment, or supplies specified on a health care claim.

(8) "Authority" means the Oregon Health Authority.

(9) "Billing provider" means the individual or entity that submits claims for health care services, equipment, or supplies delivered by an attending provider.

(10) "Capitated services" means services rendered by a provider through a contract in which payments are based upon a fixed dollar amount for each enrolled member on a monthly basis.

(11) "Carrier" shall have the meaning given that term in ORS 743.730.

(12) "Certificate of authority" shall have the meaning given that term in ORS 731.072.

(13) "Charges" means the actual dollar amount charged on the claim.

(14) "Claim" means an encounter or request for payment under the terms of an insurance policy, health benefits plan, Medicare, or Medicaid.

(15) "Co-insurance" means the percentage an enrolled member pays toward the cost of a covered service.

(16) "Coordinated Care Organization (CCO)" shall have the meaning given that term in ORS 414.025.

(17) "Co-payment" means the fixed dollar amount an enrolled member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

(18) "Data file" means electronic health information including medical claims files, eligibility files, medical provider files, pharmacy claims files, control totals files, subscriber-billed premiums files, APM files and any other related information specified in these rules.

(19) "Data set" means a collection of individual data records, whether in electronic or manual files.

(20) "DCBS" means the Oregon Department of Consumer and Business Services.

(21) "Deductible" means the total dollar amount an enrolled member pays toward the cost of covered services over an established period of time before the carrier or third-party administrator makes any payments under an insurance policy or health benefit plan.

(22) "De-identified health information" means health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

(23) "Direct personal identifier" means information relating to an individual patient or enrolled member that contains primary or obvious identifiers, including:

(a) Names;

(b) Business names when that name would serve to identify a person;

(c) Postal address information other than town or city, state, and 5-digit zip code;

(d) Specific latitude and longitude or other geographic information that would be used to derive postal address;

(e) Telephone and fax numbers;

(f) Electronic mail addresses;

(g) Social security numbers;

(h) Vehicle identifiers and serial numbers, including license plate numbers;

(i) Medical record numbers;

(j) Health plan beneficiary numbers;

(k) Certificate and license numbers;

(l) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;

(m) Biometric identifiers, including finger and voice prints; and

(n) Personal photographic images.

(24) "Disability policy" means an insurance policy that provides benefits for losses due to a covered illness or disability.

(25) "Disclosure" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

(26) "DRC" means Data Review Committee.

(27) "Dual eligible special needs plan" means a special needs plan that enrolls beneficiaries entitled to both Medicare and Medicaid.

(28) "Eligibility file" means a data set containing demographic information for each individual enrolled member eligible for medical benefits for one or more days of coverage at any time during a calendar month for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or services provided in Oregon.

(29) "Eligible employee" shall have the meaning given that term in ORS 743.730.

(30) "Employee" shall have the meaning given that term in ORS 654.005.

(31) "Employer" shall have the meaning given that term in ORS 654.005.

(32) "Encrypted identifier" means a code or other means of identification to allow individual patients or enrolled members to be tracked across data sets without revealing their identity.

(33) "Encryption" means a method by which the true value of data has been disguised in order to prevent the identification of individual patients or enrolled members and does not provide the means for recovering the true value of the data.

(34) "Enrolled member" means enrollee as defined in ORS 743.730.

(35) "ERISA" means the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001

(36) "Facility" means a health care facility as defined in ORS 442.015.

(37) "Genetic test" shall have the meaning given that term in ORS 192.531.

(38) "Group health insurance" shall have the meaning given that term in ORS 731.098.

(39) "Health benefit plan" shall have the meaning given that term in ORS 743.730.

(40) "Health care" shall have the meaning given that term in ORS 192.556.

(41) "Health care operations" means certain administrative, financial, legal, and quality improvement activities that are necessary to run programs including, but not limited to, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, evaluating practitioner, provider, or health plan performance, and underwriting, enrollment, premium rating and other activities related to creation, renewal, or replacement of a health insurance contract.

(42) "Health care provider" shall have the meaning given that term in ORS 192.556.

(43) "Health information" shall have the meaning given that term in ORS 192.556.

(44) "Health insurance exchange" shall have the meaning given that term in ORS 741.300.

(45) "Healthcare Common Procedure Coding System (HCPCS)" means a medical code set, maintained by the United States Department of Health and Human Services, that identifies health care procedures, equipment, and supplies for claim submission purposes.

(46) "HIPAA" means Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d, et seq. and the federal regulations adopted to implement the Act.

(47) "Hospital indemnity policy" means an insurance policy that provides benefits only for covered hospital stays.

(48) "Indirect personal identifier" means information relating to an individual patient or enrolled member that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render such information individually identifiable by using such information alone or in combination with other reasonably available information.

(49) "Individual", when used in a list of required lines of business, means individual health benefit plans.

(50) "Individually identifiable health information" shall have the meaning given that term in ORS 192.556.

(51) "Insurance" shall have the meaning given that term in ORS 731.102.

(52) "Labor union" means any organization which is constituted for the purpose, in whole or in part, of collective bargaining or dealing with employers concerning grievances, terms or conditions of employment or of other mutual aid or protection in connection with employees.

(53) "Large group" means health benefit plans for employers with more than 50 employees.

(54) "Limited data set" means protected health information that excludes direct personal identifiers and is disclosed for research, health care operations, or to a public health authority for public health purposes.

(55) "Long-term care insurance" shall have the meaning given that term in ORS 743.652.

(56) "Managed care organization" (MCO) means a prepaid managed care health services organization as defined in ORS 414.736.

(57) "Mandatory reporter" means any reporting entity defined as a mandatory reporter in OAR 409-025-0110.

(58) "Medicaid" means medical assistance provided under 42 U.S.C. section 1396a (section 1902 of the Social Security Act), as administered by the Division of Medical Assistance Programs.

(59) "Medicaid fee-for-service"(Medicaid FFS) means that portion of Medicaid where a health care provider is paid a fee for each covered health care service delivered to an eligible Medicaid patient.

(60) "Medical claims file" means a data set composed of health care service level remittance information for all adjudicated claims for each

billed service including but not limited to member demographics, provider information, charge and payment information, and clinical diagnosis and procedure codes for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or services provided in Oregon.

(61) "Medical provider file" means a data set containing information about health care providers providing health care services, equipment, or supplies to enrolled members during the reporting period.

(62) "Medicare" means coverage under Part A, Part B, Part C, or Part D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(63) "Medicare Modernization Act" means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003(Public Law 108-173) and the federal regulations adopted to implement the Act.

(64) "OEBB" means the Oregon Educators Benefit Board.

(65) "OMIP" means the Oregon Medical Insurance Pool.

(66) "Patient" means any person in the data set who is the subject of the activities of the claim performed by the health care provider.

(67) "Paid amount" means the actual dollar amount paid for claims.

(68) "PEBB" means the Oregon Public Employees' Benefit Board.

(69) "Person" shall have the meaning given that term in ORS 731.116.

(70) "Pharmacy benefit manager (PBM)" means a person or entity that performs pharmacy benefit management, including a person or entity in a contractual or employment relationship with a person or entity performing pharmacy benefit management for a health benefits plan.

(71) "Pharmacy claims file" means a data set containing service level remittance information from all adjudicated claims including, but not limited to, enrolled member demographics, provider information, charge and payment information, and national drug codes for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or services provided in Oregon.

(72) "Pharmacy eligibility file" means a data set containing demographic information for each individual enrolled member eligible for pharmacy benefits for one or more days of coverage at any time during a calendar month for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or services provided in Oregon.

(73) "Policy" shall have the meaning given that term in ORS 731.122.

(74) "Prepaid amount" means the fee for the service equivalent that would have been paid for a specific service if the service had not been capitated.

(75) "Premium" shall have the meaning given that term in ORS 743.730.

(76) "Principal investigator (PI)" means the person in charge of a research project that makes use of limited data sets. The PI is the custodian of the data and shall comply with all state and federal restrictions, limitations, and conditions of use associated with the data release.

(77) "Protected health information" shall have the meaning given that term in ORS 192.519.

(78) "Public health authority" means the Public Health Division of the Authority or local public health authority as defined in ORS 431.260.

(79) "Public health purposes" means the activities of a public health authority for the purpose of preventing or controlling disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, investigations, and interventions.

(80) "Public use data set" means a publicly available data set of de-identified health information containing only the data elements specified by the Authority for inclusion.

(81) "Registered entity" means any person required to register with DCBS under ORS 744.714.

(82) "Reporting entity" means:

(a) An insurer as defined in ORS 731.106 or fraternal benefit society as defined in ORS 748.106 required to have a certificate of authority to transact health insurance business in Oregon.

(b) A health care service contractor as defined in ORS 750.005 that issues medical insurance in Oregon.

(c) A third-party administrator required to obtain a license under ORS 744.702.

(d) A pharmacy benefit manager or fiscal intermediary, or other person that is by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service.

(e) A prepaid managed care health services organization as defined in ORS 414.736.

(f) An insurer providing coverage funded under Part A, Part B, or Part D of Title XVIII of the Social Security Act, subject to approval by the United States Department of Health and Human Services.

(83) "Research" means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalized knowledge.

(84) "Self-insured plan" means any plan, program, contract, or any other arrangement under which one or more employers, unions, or other organizations provide health care services or benefits to their employees or members in this state, either directly or indirectly through a trust or third-party administrator.

(85) "Small employer health insurance" means health benefit plans for employers whose workforce consists of at least two but not more than 50 eligible employees.

(86) "Special Needs Plan" means a Medicare health benefit plan created by the Medicare Modernization Act that is specifically designed to provide targeted care to individuals with special needs.

(87) "Specific disease policy" means an insurance policy that provides benefits only for a loss due to a covered disease.

(88) "Strongly-encrypted" means an encryption method that uses a cryptographic key with a large number of random keyboard characters.

(89) "Subscriber" means the individual responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health benefit plan.

(90) "Summarized data" means data aggregated by one or more categories. Summarized data created from protected health information may not contain direct or indirect identifiers.

(91) "Third-party administrator (TPA)" means any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on, residents of Oregon or residents of another state from offices in Oregon, in connection with life insurance or health insurance coverage; or any person or entity who must otherwise be licensed under ORS 744.702.

(92) "Transact insurance" shall have the meaning given that term in ORS 731.146.

(93) "Trust" means a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association.

(94) "Vision policy" means a health benefits plan covering only vision health care.

(95) "Voluntary reporter" means any registered or reporting entity, other than a mandatory reporter, that voluntarily elects to comply with the reporting requirements in OAR 409-025-0100 to 409-025-0170.

Stat. Auth.: ORS 442.466

Stats. Implemented: ORS 442.464 & 442.466

Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef. 6-1-12; OHP 5-2012(Temp), f. 6-23-12, cert. ef. 6-1-12 thru 11-15-12; OHP 6-2012; f. 6-26-12, cert. ef. 7-9-12; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17

409-025-0110

General Reporting Requirements

(1) Definition of "mandatory reporter"

(a) For carriers and licensed third-party administrators, the Authority shall identify mandatory reporters using information collected by DCBS including, but not limited to, data from the Health Insurance Member Enrollment Report.

(A) The Authority shall aggregate the most recent four quarters of data.

(B) The Authority shall calculate the mean total lives for each carrier and licensed third-party administrator.

(C) All carriers and licensed third-party administrators with calculated mean total lives of 5,000 or higher shall be mandatory reporters.

(b) All PBMs shall be mandatory reporters.

(c) All MCOs shall be mandatory reporters.

(d) All CCOs shall be mandatory reporters.

(e) All reporting entities with Dual Eligible Special Needs Plans in Oregon shall be mandatory reporters.

(f) All insurers providing coverage funded under Part A, Part B or Part D of Title XVIII of the Social Security Act, subject to approval by the United States Department of Health and Human Services.

(g) All insurers offering a health benefits plan in Oregon's health insurance exchange shall be mandatory reporters.

(2) Voluntary reporters may elect to participate by notifying the Authority in writing.

(3) Mandatory and voluntary reporters shall submit data files for all required lines of business. They may submit data files for the voluntary lines of business and may not submit data files for any excluded lines of business.

(a) Required lines of business include:

(A) Medicare (parts C and D);

(B) Medicaid;

(C) Individual;

(D) Small employer health insurance;

(E) Large group;

(F) Associations and trusts;

(G) PEBB and OEBB group health insurance plans; and

(H) Self-insured plans not subject to ERISA.

(b) Voluntary lines of business include self-insured plans subject to ERISA.

(c) Excluded lines of business include:

(A) Accident policy;

(B) Dental insurance;

(C) Disability policy;

(D) Hospital indemnity policy;

(E) Long-term care insurance;

(F) Medicare supplemental insurance;

(G) Specific disease policy;

(H) Stop-loss plans;

(I) Student health policy;

(J) Vision-only insurance; and

(K) Workers compensation.

(4) Mandatory and voluntary reporters shall comply with data file layout, format, and coding requirements in OAR 409-025-0120.

(5) Mandatory and voluntary reporters shall comply with data submission requirements in OAR 409-025-0130.

(6) Unless otherwise required by state or federal rules, regulations or statutes, mandatory and voluntary reporters may not submit claims subject to stricter disclosure limits imposed by state or federal rules, regulations, or statutes.

(7) The Authority shall provide written notification by July 1 of each year to all mandatory reporters subject to the reporting requirements of OAR 409-025-0100 to 409-025-0170 for the following calendar year.

Stat. Auth.: ORS 442.466

Stats. Implemented: ORS 442.464 & 442.466

Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef. 6-1-12; OHP 5-2012(Temp), f. 6-23-12, cert. ef. 6-1-12 thru 11-15-12; OHP 6-2012; f. 6-26-12, cert. ef. 7-9-12; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17

409-025-0120

Data File Layout, Format, and Coding Requirements

(1) All data files shall include:

(a) Medical claims;

(b) Eligibility;

(c) Medical provider;

(d) Pharmacy claims;

(e) Control totals;

(f) Subscriber billed premiums;

(g) Annual supplemental provider level APM summary; and

(h) Control totals for annual supplemental provider level APM summary.

(2) The medical claims file shall be submitted using the approved layout, format, and coding described in Appendix A.

(3) The eligibility file shall be submitted using the approved layout, format, and coding described in Appendix B.

(a) Mandatory reporters shall report race and ethnicity data as outlined in Appendix B. This layout aligns with the Office of Management and Budget's (OMB) Federal Register Notice of October 30, 1997 (62 FR 58782-58790).

(b) Mandatory reporters shall report primary language in accordance with ANSI/NISO guidance using the three-character string outlined in Codes for the Representation of Languages for Information Interchange.

(c) Race, ethnicity and primary language data shall be collected in a manner that aligns with the following principles:

(A) To the greatest extent practicable, race, ethnicity, and preferred language shall be self-reported.

(i) Collectors of race, ethnicity and primary language data may not assume or judge ethnic and racial identity or preferred signed, written and spoken language, without asking the individual.

(ii) If an individual is unable to self-report and a family member, advocate, or authorized representative is unable to report on his or her behalf, the information shall be recorded as unknown.

(B) When an individual declines to identify race, ethnicity or preferred language, the information shall be reported as refused.

(4) The medical provider file shall be submitted using the approved layout, format, and coding described in Appendix C.

(5) The pharmacy claims file shall be submitted using the approved layout, format, and coding described in Appendix D.

(6) The control totals file shall be submitted using the approved layout, format, and coding described in Appendix E.

(7) The subscriber billed premium file shall be submitted using the approved layout, format, and coding described in Appendix F.

(8) The annual supplemental provider level APM summary file shall be submitted using the approved layout, format, and coding described in Appendix G.

(9) The control totals for annual supplemental provider level APM summary file shall be submitted using the approved layout, format, and coding described in Appendix H.

(10) All data elements are required unless specified as optional or situational.

(11) All required data files shall be submitted as delimited ASCII files.

(12) Numeric data are positive integers unless otherwise specified.

(a) Negative values are allowed for revenue codes, quantities, charges, payment, co-payment, co-insurance, deductible, and prepaid amount.

(b) Negative values shall be preceded by a minus sign.

(13) The Authority shall convene a technical advisory group to advise the Authority and associated contractors on submission specifications including but not limited to Appendices A-H, Schedule A and any additional data submission requirements. The advisory group shall include, but is not limited to representatives from:

(a) Mandatory reporters;

(b) Providers;

(c) Researchers, and;

(d) Other stakeholders and interested parties.

(14) All data files shall pass edit checks and validations implemented by the Authority or the data vendor.

(a) Data vendors may perform quality and edit checks on data file submissions. If data files do not pass data vendor edit checks or validation, mandatory reporters must make corrections and resubmit data. Mandatory reporters must submit corrected data or an exception request within 14 calendar days of notification of error.

(b) Mandatory reporters must participate in efforts to validate and check the quality of current and historic APAC data, as prescribed and requested by the Authority.

(A) The Authority may request from mandatory reporters information from their internal records that is reasonably necessary to validate and check the quality of APAC data. This information may include, but is not limited to, aggregated number of enrolled members, number of claims and claim lines, charges, allowed amounts, paid amounts, co-insurance, co-payments, premiums, number of visits to primary care, emergency department, inpatient, and other health care treatment settings, and number of prescriptions.

(B) Mandatory reporters shall provide the aggregated information within 30 days of the Authority's request.

(C) If the Authority finds errors through edit checks or validation, mandatory reporters must make corrections and resubmit data or submit an exception request within 30 days or at the next regularly scheduled submission due date.

[ED. NOTE: Appendices and Schedules referenced are avaliable from the agency.]

Stat. Auth.: ORS 442.466

Stats. Implemented: ORS 442.464 & 442.466

Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef. 6-1-12; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17

409-025-0130

Data Submission Requirements

(1) Mandatory reporters shall submit data files as specified in Schedule A. Voluntary reporters may consult with the Authority to submit healthcare claims data files on an alternative schedule.

(2) Mandatory and voluntary reporters shall submit data files directly to the data vendor unless otherwise specified by the Authority.

(3) Mandatory and voluntary reporters shall transmit data files using one of the following approved processes:

(a) Secure file transfer protocol (SFTP) including separate strong encryption of data files prior to SFTP transmission; or

(b) Any process incorporating strong encryption that is approved in writing by both the Authority and the data vendor.

[ED. NOTE: Schedule A referenced is available from the agency]
Stat. Auth.: ORS 442.466
Stats. Implemented: ORS 442.464 & 442.466
Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef. 6-1-12; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17

409-025-0150
Compliance and Enforcement

Penalties for failure to comply shall be enforced by the Authority.

(1) Unless approved by a waiver or exception, failure to comply with general reporting requirements shall include but is not limited to:

(a) Failure to submit data files for a required line of business; and

(b) Submitting health information for an excluded line of business.

(2) Unless approved by a waiver or exception, failure to comply with data file requirements shall include but is not limited to:

(a) Submitting a data file in an unapproved layout;

(b) Submitting a data element in an unapproved format;

(c) Submitting a data element with unapproved coding;

(d) Failure to submit a required data element; or

(e) Failure to comply with validation and quality control efforts, including resubmitting or correcting data as requested by the Authority.

(3) Unless approved by a waiver or exception, failure to comply with data submission requirements shall include but is not limited to:

(a) Failure to submit test files as specified by the data vendor;

(b) Submitting data files later than five days after the submission due date as outlined in Schedule A;

(c) Rejection of a data file by the data vendor that is not resubmitted or corrected by the submitter within 14 calendar days from notification of error; or

(d) Transmitting data files using an unapproved process.

(4) The Authority shall provide mandatory reporters written notification of each failure to comply.

(5) The Authority may impose fines of up to $500 per day for each failure to comply that is not resolved within 30 calendar days of written notification.

(6) If a mandatory reporter has made documented efforts to comply with these rules, the Authority may consider this a mitigating factor before imposing regulatory action against the mandatory reporter.

[ED. NOTE: Schedule A referenced is available from the agency.]
Stat. Auth.: ORS 442.466 & 442.993
Stats. Implemented: ORS 442.464, 442.466 & 442.993
Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17

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Rule Caption: Establishes rules relating to Primary Care Services Reporting by Coordinated Care Organizations
Adm. Order No.: OHP 11-2016
Filed with Sec. of State: 7-8-2016
Certified to be Effective: 7-8-16
Notice Publication Date: 6-1-2016
Rules Adopted: 409-027-0005, 409-027-0015, 409-027-0025
Subject: The Oregon Health Authority needs to adopt rules to implement the requirements of House Bill 4017 (2016 legislature) which amended Chapter 575, Section 3 of 2015 Oregon Laws (SB 231). The laws require non-claims based primary care expenditures and non-claims based total health care expenditures must be reported to the Oregon Health Authority by Coordinated Care Organizations. These rules define the type of providers and data to be reported to the Authority by October 1 of each year through December 31, 2018.
Rules Coordinator: Zarie Haverkate—(503) 931-6420

409-027-0005
Purpose and Scope

These rules (OAR 409-027-0005 to 409-027-0025) define primary care services that must be reported by all Coordinated Care Organizations to the Oregon Health Authority no later than October 1 of 2016–2018 for the prior calendar year's data. The findings generated from these reports will be presented to the legislature no later than February 1 of 2017 - 2020.

Stat. Auth: 413.042; Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Stats. Implemented: Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Hist.: OHP 11-2016, f. & cert. ef. 7-8-16

409-027-0015
Definitions

The following definitions apply:

(1) "Authority" means the Oregon Health Authority.

(2) "Coordinated care organization (CCO)" has the meaning given that term in ORS 414.025.

(3) "Non-claims based primary care expenditures" means resources given to a primary care provider or practice for the following services or arrangements:

(a) Capitation and salaried arrangements with primary care providers or practices not billed or captured through claims.

(b) Risk-based reconciliation for arrangements with primary care providers or practices not billed or captured through claims.

(c) Payments to Patient-Centered Primary Care Homes or Patient-Centered Medical Homes based upon that recognition or payments for participation in proprietary or other multi-payer medical home initiatives.

(d) Retrospective incentive payments to primary care providers or practices based on performance aimed at decreasing cost or improving value for a defined population of patients.

(e) Prospective incentive payments to primary care providers or practices aimed at developing capacity for improving care for a defined population of patients.

(f) Payments for Health Information Technology structural changes at a primary care practice such as electronic records and data reporting capacity from those records.

(g) Workforce expenses including payments or expenses for supplemental staff or supplemental activities integrated into the primary care practice such as practice coaches, patient educators, patient navigators, and nurse care managers.

(4) "Non-claims based total health care expenditures" means resources given to a provider or practice for the following services or arrangements:

(a) Capitation or salaried arrangements with providers or practices not billed or captured through claims.

(b) Risk-based reconciliation for arrangements with providers or practices not billed or captured through claims.

(c) Payments to Patient-Centered Primary Care Homes, Patient-Centered Medical Homes, or Patient-Centered Specialty Practices based upon that recognition or payments for participation in proprietary or other multi-payer medical home or specialty care practice initiatives.

(d) Retrospective incentive payments to providers or practices based on performance aimed at decreasing cost or improving value for a defined population of patients.

(e) Prospective incentive payments to providers or practices aimed at developing capacity for improving care for a defined population of patients.

(f) Payments for Health Information Technology structural changes at a practice such as electronic records and data reporting capacity from those records.

(g) Workforce expenses including payments or expenses for supplemental staff or supplemental activities integrated into the practice such as practice coaches, patient educators, patient navigators, and nurse care managers.

(5) "Patient-Centered Medical Home (PCMH)" means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.

(6) "Patient-Centered Primary Care Home (PCPCH)" means a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

(7) "Patient Centered Specialty Practice (PCSP)" means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.

(8) "Practice" means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BPs unless otherwise specified.

(9) "Primary care" means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

(10) "Primary care provider" means:

(a) A physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care.

(b) A health care team or clinic certified by the Authority as a PCPCH.

Stat. Auth: 413.042; Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Stats. Implemented: Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Hist.: OHP 11-2016, f. & cert. ef. 7-8-16

409-027-0025
Coordinated Care Organization (CCO) Reporting Requirements

(1) No later than October 1 of each year from 2016 through 2018 each CCO shall submit all non-claims based primary care expenditures as defined in OAR 409-027-0020 for the prior calendar year's data [Example: January 1, 2015 through December 31, 2015 data needs to be submitted by October 1, 2016] using the approved file layout and format available at: http://www.oregon.gov/OHA/OHPR/pages/rulemaking/index.aspx.

(2) No later than October 1 of each year from 2016 through 2018 each CCO shall submit all non-claims based total health care expenditures as defined in OAR 409-027-0020 for the prior calendar year's data [Example: January 1, 2015 through December 31, 2015 data needs to be submitted by October 1, 2016] using the approved file layout and format available at: http://www.oregon.gov/OHA/OHPR/pages/rulemaking/index.aspx.

(3) Each category included in the approved file format is mutually exclusive; therefore, expenditures shall only be accounted for in one category.

(4) Claims-based primary care and total health care expenditures will be calculated for each CCO by the Authority using data from the Authority's All-Payer All-Claims Database.

(5) Expenditures for services or activities outside the primary care setting, regardless of a primary care capacity building intent, are not considered primary care expenditures for purposes of this report.

NOTE: Other CCO rules can be found at OAR 410-141-3000 to 410-141-3485
Stat. Auth: 413.042; Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Stats. Implemented: Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Hist.: OHP 11-2016, f. & cert. ef. 7-8-16

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Oregon Health Authority, Health Systems Division: Addiction Services Chapter 415

Rule Caption: Temporary amendments to OAR 415-012 titled "Licensure of Alcohol and Other Drug Abuse Treatment Programs".
Adm. Order No.: ADS 2-2016(Temp)
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 415-012-0000, 415-012-0010, 415-012-0020, 415-012-0030, 415-012-0035, 415-012-0040, 415-012-0050, 415-012-0055, 415-012-0060, 415-012-0065, 415-012-0067, 415-012-0070, 415-012-0090
Subject: These rules establish procedures for the residential licensure of the following:

(1) Any substance use disorder service provider which is, or seeks to be, contractually affiliated with the Health Systems Division (HSD), a Coordinated Care Organization, or a local mental health authority for the purpose of providing residential alcohol and other drug abuse treatment and prevention services;

(2) Any service provider using public funds in the provision of residential substance use disorder prevention, intervention, or treatment services in Oregon;

(3) Performing providers under AMH rules OAR 309-016-0000 through 309-016-0120;

(4) Organizations seeking approval from the Division for provision of residential services as provided in ORS 430.010 and 443.400 or detoxification services under ORS 430.306; or

(5) Alcohol and drug evaluation specialists designated to do Driving Under the Influence of Intoxicants (DUII) diagnostic screenings and assessments under ORS 813.020 and 813.260.

Scope. These rules do not establish procedures for regulating behavioral health care practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes. These rules do not establish procedures for regulating practices exclusively comprised of behavioral healthcare practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes. These rules do not establish procedures for regulating behavioral health treatment services.
Rules Coordinator: Nola Russell—(503) 945-7652

415-012-0000
Purpose and Scope

Purpose. These rules establish procedures for the residential licensure of the following:

(1) Any substance use disorder service provider which is, or seeks to be, contractually affiliated with the Health Systems Division (HSD), a Coordinated Care Organization, or a local mental health authority for the purpose of providing residential alcohol and other drug abuse treatment and prevention services;

(2) Any service provider using public funds in the provision of residential substance use disorder prevention, intervention, or treatment services in Oregon;

(3) Performing providers under HSD rules OAR 410-172-0600 through 410-172-0860;

(4) Organizations seeking approval from the Division for provision of residential services as provided in ORS 430.010 and 443.400 or detoxification services under ORS 430.306; or

(5) Alcohol and drug evaluation specialists designated to do Driving Under the Influence of Intoxicants (DUII) diagnostic screenings and assessments under ORS 813.020 and 813.260.

(6) Scope. These rules do not establish procedures for regulating behavioral health care practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes. These rules do not establish procedures for regulating practices exclusively comprised of behavioral healthcare practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes. These rules do not establish procedures for regulating behavioral health treatment services.

Stat. Auth.: ORS 413.042 & 430.256
Stats. Implemented: ORS 430.010, 430.306, 430.397, 430.405, 430.450, 430.590, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 2-2013(Temp), f. & cert. ef. 1-14-13 thru 7-12-13; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 1-2014(Temp), f. & cert. ef. 1-28-14 thru 7-21-14; ADS 3-2014, f. 6-10-14, cert. ef. 6-19-14; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0010
Definitions

(1) "Applicant" means any person or entity who has requested, in writing, a license.

(2) "Chief Officer" means the Chief Health Systems Officer of the HSD, or his or her designee.

(3) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disturbances, drug use problems, mental retardation or other developmental disabilities, and alcoholism and alcohol use problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(4) "Coordinated Care Organization (CCO)" means an entity that has been certified by the Authority to provide coordinated and integrated health services.

(5) "Contract" is the document describing and limiting the relationship and respective obligations between an organization other than a county and the Division for the purposes of operating the alcohol and drug use disorder service within a county's boundaries, or operating a statewide, regional, or specialized service.

(6) "Division" means the Health Systems Division (HSD) of the Oregon Health Authority.

(7) "Individual" means the person requesting or receiving services addressed in these rules.

(8) "Intergovernmental Agreement" or "Agreement" is the document describing and limiting the contractual relationship and respective obligations between a county or other government organization and the Division for the purpose of operating an alcohol and drug use disorder service.

(10) "License" means a license issued by the Division to applicants who are in substantial compliance with applicable administrative rules for alcohol and drug use treatment in a residential setting and which is renewable every two years.

(11) "Licensed Child Care Facility" means a facility licensed under ORS 657A.280.

(12) "Non-Funded Provider" means an organization not contractually affiliated with the Division, a CMHP, or other contractor of the Division.

(13) "Provider" means an organization licensed under these rues whom is providing substance abuse prevention, intervention, or treatment services under contract with the Division or under subcontract with a local

entity or public body or otherwise receiving public funds for these services.

(14) "Provisional" means a license issued for one year or less pending completion of specified requirements because of substantial failure to comply with applicable administrative rules.

(15) "Quality Assurance" means the process of objectively and systematically monitoring and evaluating the quality and appropriateness of care to identify and resolve identified problems.

(16) "Restriction" means any limitations placed on a license such as age of individuals to be served or number of individuals to be served.

(17 "Revocation" means the removal of authority for a provider to provide certain services under a license.

(18) "School Attended Primarily By Minors" means an existing public or private elementary, secondary or career school attended primarily by individuals under age eighteen.

(19) "Service Element" means a distinct service or group of services for persons with alcohol or other drug use disorders defined in administrative rule and included in a contract or agreement issued by the Division.

(21) "Substantial Compliance" means a level of adherence to applicable administrative rules which, while not meeting one or more of the requirements, does not, in the determination of the Division:

(a) Constitute a danger to the health or safety of any individual;

(b) Constitute a willful or ongoing violation of the rights of service recipients as set forth in administrative rules; or

(c) Prevent the accomplishment of the state's purposes in approving or supporting the subject service.

(22) "Substantial Failure to Comply" is used in this rule to mean the opposite of "substantial compliance."

(23) "Suspension" means a temporary removal of authority for a provider to conduct a service for a stated period of time or until the occurrence of a specified event under a LOA or license.

(24) "Temporary" means a LOA license issued for 185 days to a program approved for the first time. A temporary LOA license cannot be extended.

(25) "Variance or Exception" means a waiver of a regulation or provision of these rules granted by the Division upon written application.

Stat. Auth.: ORS 413.042 & 430.256
Stats. Implemented: ORS 430.010 - 430.030, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADAP 1-2001, f. 3-29-01, cert. ef. 4-1-01; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 2-2013(Temp), f. & cert. ef. 1-14-13 thru 7-12-13; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0020
General Requirements

(1) Providers That Must Have a License: Every provider that operates a residential service element by contract with the Division or subcontracts with a local entity or public body or otherwise receives public funds for providing substance abuse prevention, intervention, or treatment services must have a license:

(a) No provider shall represent themselves as conducting any service described in this rule without first obtaining a license;

(b) A provider that does not have a license for conducting a service described in this rule may not admit a person needing that service; and

(c) The license shall be posted in the facility and available for inspection at all times.

(2) Licensed providers must also maintain a current certificate of approval for the provision of behavioral health treatment services per OAR 309-008-0100 to 309-008-1600 if also providing an outpatient service.

(3) Facilities Requiring License: Any facility which meets the definition of a residential treatment facility for substance-dependent persons under ORS 443.400 or a detoxification center as defined in ORS 430.306 must be licensed by the Division:

(a) No individual or entity shall represent themselves as a residential treatment facility for substance-dependent persons or as a detoxification center without first being licensed;

(b) A residential treatment facility or a detoxification center that is not licensed may not admit individuals needing residential or detoxification care or treatment; and

(c) A license shall be posted in the facility and available for inspection at all times.

(4) License is not a Contract: Approval or licensure of a service element pursuant to this rule does not create an express or implied contract in the absence of a fully executed written contract.

(5) Distance Requirements for Methadone Treatment Programs: Programs using methadone to treat opioid addiction may not operate within 1,000 linear feet of a licensed child care facility or school primarily attended by minors pursuant to ORS 430.590. The Division will not issue a variance to programs unable to meet this requirement.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 430.010-030, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 2-2013(Temp), f. & cert. ef. 1-14-13 thru 7-12-13; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0030
Initial Application Procedures

(1) Application Packet: The Division shall mail an application packet to all applicants seeking residential licensure under these rule.

(2) Initial Meeting: All programs applying for the first time for a residential license to operate a treatment or prevention program shall schedule a meeting with Division staff for the purpose of receiving needed technical assistance regarding the approval and licensure criteria and procedures.

(3) Multiple Locations: A separate application is required for each location where the provider intends to operate a residential treatment facility.

(4) Withdrawal of Application: The applicant may withdraw the application at any time during the application process by notifying the Division in writing. At such time, all materials shall be returned to the applicant.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 430.010-030, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 2-2013(Temp), f. & cert. ef. 1-14-13 thru 7-12-13; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0035
Responses To Application

(1) Application Satisfactory: If the application is found to be complete and if the material documents compliance with applicable administrative rules, the Division shall issue a license no later than 30 days after final approval of the application.

(2) Unsatisfactory Application: If the application is not complete or if the application does not document compliance:

(a) The applicant shall be provided with written notification that identifies needed information or areas of non-compliance within 60 days of receipt of the application; and

(b) The original application shall be kept on file for 60 days after written notice has been given, at which time, if no further material is submitted to correct the deficiencies noted, the application shall be denied and all material shall be returned to the applicant.

(3) Application Denied: If a license is denied:

(a) The applicant shall be entitled to a hearing with the Chief Officer if the applicant requests a hearing in writing within 60 days of the receipt of the notice;

(b) The Assistant Chief Officer, whose decision is final, shall hold a hearing within 60 days of receipt of the written request; and

(c) If no written request for a hearing is received within the 60-day timeline, the notice of denial shall become the final order by default and the Chief Officer may designate its file as the record for purposes of order by default.

Stat. Auth.: ORS 413.042 & 430.256
Stats. Implemented: ORS 430.010-30, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0040
Licenses

The Division may issue a residential license under these rules for a duration not to exceed two years.

(1) Renewal: Renewal of licenses shall be contingent upon demonstration of compliance with appropriate administrative rules:

(a) A program may continue to operate until final determination of its approval or licensure status is made by the Division;

(b) Failure to demonstrate compliance may result in the issuance of a provisional license, suspension, or revocation.

(2) Provisional Certification: Programs with provisional licenses upon demonstrating substantial compliance with appropriate administrative rules may be eligible for a two-year license. However, the provider's failure to demonstrate substantial compliance may result in an extension, suspension, or revocation of the provisional license.

(3) Nondiscrimination; Special Populations: The Division shall not discriminate in its review procedures or services on the basis of race, color, national origin, age, or disability. The Division may issue licenses to specialized programs to assure maximum benefit for special populations, in

which case, the Division may identify that special population in the license and impose applicable program criteria.

(4) Restrictions: Restrictions which may be attached to a license include:

(a) Limiting the total number of individuals (in residential or detoxification treatment);

(b) Defining the age level of individuals (i.e., youth or adult) to be admitted into the facility;

(c) Defining the gender of individuals, if the provider is identified as serving only males or females;

(d) Assuring compliance with other licensing entities such as the CAF Division, the State Public Health Division, or the Food and Drug Administration; or

(e) Other restrictions as required by the Division.

(5) Time Limits on Restrictions: Restrictions may be imposed for the extent of the approval period or limited to some other shorter period of time. If the restriction corresponds to the licensing period, the reasons for the restriction shall be considered at the time of renewal to determine if the restrictions are still appropriate.

(6) Restriction to Appear on License: The effective date and expiration date of the restriction shall be indicated on the certificate.

(7) Non-Transferability: A license issued by the Division for the operation of a residential substance use disorder program applies both to the applicant program and the premises upon which the program is to be operated. A license is not transferable to another person, entity, or to any other location:

(a) Any person or other legal entity acquiring an approved licensed facility for the purpose of operating a substance use disorder program shall make an application as provided herein for a new LOA or license;

(b) Any person or legal entity having been issued a license and desiring to fundamentally alter the treatment philosophy or transfer to different premises must notify the Division 30 days prior to doing so in order for the Division to review the program or site change and to determine further necessary action.

(8) Change of Administrator: If the administrator of the program changes during the period covered by the license:

(a) A request for a change must be submitted to the Division within 15 days, along with the qualifications of the proposed new administrator;

(b) Upon a determination that the administrator meets the requirements of applicable administrative rules, a revised license shall be issued with the name of the new administrator.

(9) Discontinued Program: When a program is discontinued, its current license is void immediately and the certificate shall be returned to the Division. A discontinued program is one which has terminated its services for which it has been approved or licensed. A program planning to discontinue services must:

(a) Notify the Division 60 days prior to a voluntary closure of a facility with written notice of how the provider will comply with OAR 309-014-0035(4) and 42 CFR Part 2, Federal Confidentiality Regulations, regarding the preservation of all individual records; and

(b) Provide individuals 30 days written notice and shall be responsible for making reasonable efforts to obtain treatment placement of individuals as appropriate.

Stat. Auth.: ORS 430.256

Stats. Implemented: ORS 430.397, 430.010-030, 430.306, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500

Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADAP 1-2001, f. 3-29-01, cert. ef. 4-1-01; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0050

Onsite Reviews and Access Requirements

(1) Scheduled Inspections: The Division shall inspect the facilities and must review procedures utilized:

(a) Before issuing a LOA or license to an applicant; and

(b) Before renewal of an existing LOA or license.

(2) Discretionary Onsite Inspections: The Division may conduct onsite inspections:

(a) Upon receipt of verbal or written complaints of violations that allege conditions that may threaten the health, safety, or welfare of individuals or for any other reason to be concerned for individual welfare; or

(b) Any time the Division has reason to believe it is necessary to assure if a provider is in compliance with the administrative rules or with conditions placed upon the license.

(3) Substance of Reviews: The review may include but is not limited to case record audits and interviews with staff and individuals, consistent with the confidentiality safeguards of state and federal laws.

(4) Access to Facilities and Records: Each applicant or provider agrees, as a condition of license approval:

(a) To permit designated representatives of the Division to inspect premises of programs to verify information contained in the application or to assure compliance with all laws, rules, and regulations during all hours of operation of the facility and at any other reasonable hour;

(b) To permit properly designated representatives of the department to audit and collect statistical data from all records maintained by the approved or licensed program; and

(c) That such right of immediate entry and inspection shall, under due process of law, extend to any premises on which the Division has reasons to believe a program is being operated by the provider in violation of these rules.

(5) Access if Requirement for License: An applicant or provider shall not be granted licensing which does not permit inspection by the Division or examination of all records, including financial records as appropriate, methods of administration, the disbursement of drugs and method of supply, and any other records the Division considers to be relevant to the establishment of such a program.

(6) Inspection by Other Agencies: Each applicant or provider agrees, as a condition of license approval that:

(a) State or local fire inspectors shall be permitted access to enter and inspect the facility regarding fire safety upon the request of the Division; and

(b) State or local health inspectors shall be permitted access to enter and inspect the facility regarding health safety upon the request of the Division.

(7) Notice: The Division has authority to conduct inspections with or without advance notice to the administrator, staff, or individuals:

(a) The Division is not required to give advance notice of any onsite inspection if the Division reasonably believes that notice might obstruct or seriously diminish the effectiveness of the inspection or enforcement of these administrative rules; and

(b) If Division staff are not permitted access for inspection, a search warrant may be sought.

Stat. Auth.: ORS 409.410

Stats. Implemented: ORS 430.397, 430.010-030, 430.306, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500

Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADS 2-2007, f. & cert. ef. 5-25-07; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0055

Review Process and Review Reports

(1) For renewal of a license: The Division shall designate a lead specialist and other onsite review members as appropriate to perform a formal onsite review of the service element or elements;

(2) Access to Reports: Public access to final reports of onsite inspections, except for confidential information, shall be available upon written request from the Division during business hours in accordance with OAR chapter 407, division 003.

(3) Corrective Action Plan. Programs issued a provisional license must submit an action plan to the Chief Officer or his or her designee for approval no later than 30 days following receipt of the final onsite report. The corrective action plan shall include, but not be limited to:

(a) Specific problem areas cited as out of compliance;

(b) A delineation of corrective measures to be taken by the program to bring the program into compliance; and

(c) A delineation of target dates for completion of corrective measures for each problem area.

(4) Failure to Take Corrective Action: Failure to demonstrate compliance with the corrective action plan may result in an extension, suspension or revocation of the provisional license.

Stat. Auth.: ORS 413.042 & 430.256

Stats. Implemented: ORS 430.010-30, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500

Hist.: ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0060

Denial, Revocation, or Non-renewal

(1) Denial of Application or Request for Renewal: The Division shall deny an application or request for renewal, or revoke a license where it finds any of the following:

(a) The provider has substantially failed to comply with applicable administrative rules or with local codes and ordinances or any other applicable state or federal law or rule;

(b) The applicant or provider has had a prior LOA or license to operate an alcohol and drug use disorder treatment program denied, revoked, or refused to be renewed in any county in Oregon within three years preceding the present application for reason of abuse or neglect of individuals or the administrator's failure to possess adequate physical health, mental health, or good personal character;

(c) If such prior denial, revocation, or refusal to renew occurred more than three years from the present action, the provider is required to establish to the Division by clear and convincing evidence his or her ability and fitness to operate a treatment program. If the applicant or provider does not provide such evidence, the Division shall deny the application;

(d) The applicant or provider submits fraudulent or untrue information to the Division;

(e) The applicant or provider has a history of, or currently demonstrates, financial insolvency such as filing for bankruptcy, foreclosures, eviction due to failure to a pay rent, termination of utility services due to failure to pay bills, failure to pay taxes such as employment or social security in a timely manner;

(f) The applicant or provider refuses to allow immediate access and onsite inspection by the Division; or

(g) The applicant or provider fails to maintain sufficient staffing or fails to comply with staff qualifications requirements.

(2) Notification of Denial: When the Division determines that an applicant's request for alicense should be denied, the Chief Officer or designee shall notify the applicant, by certified mail, return receipt requested, of the Division's decision to deny the licensure and the reasons for the denial.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 430.397, 430.010-030, 430.306, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADAP 1-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0065
Suspension of License

If the Division finds that the health, safety, or welfare of the public are seriously endangered by continued operation of a treatment or prevention program and sets forth specific reasons for its findings, summary suspension of a license may be ordered. The Division may suspend a license for any of the following reasons:

(1) Violation by the program, its director or staff, of any rule promulgated by this Division pertaining to treatment or prevention services;

(2) Permitting, aiding or abetting the commitment of an unlawful act within the facilities maintained by the program, or permitting, aiding or abetting the commitment of an unlawful act involving chemical substances within the program;

(3) Conduct or practices found by the Division to be detrimental to the general health or welfare of an individual in the program; or

(4) Deviation by the program from the plan of operation originally approved or licensed which, in the judgment of the Division, adversely affects the character, quality or scope of services intended to be provided to individuals within the program.

Stat. Auth.: ORS 413.042 & 430.256
Stats. Implemented: ORS 430.010-30, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0067
Response to Criminal Records

(1) The Division may deny, refuse to renew, suspend, or revoke alicense if:

(a) Any of the program's staff, within the previous three years, has been convicted of:

(A) Any crime or violation under ORS Chapter 475, including but not limited to the Uniform Controlled Substances Act, or under ORS 813.010, driving under the influence of intoxicants;

(B) A substantially similar crime or violation in any other state; or

(C) Any felony.

(b) Any of the program's staff has entered into, within the past three years, a diversion agreement under ORS 813.010 or 135.907 through 135.921, or a diversion agreement under a substantially similar law in any other state;

(2) Criminal Record Checks: The Chief Officer or designee may make criminal record inquiries necessary to ensure implementation of these rules.

Stat. Auth.: ORS 413.042 & 430.256
Stats. Implemented: ORS 430.010-30, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0070
Hearings

(1) Requesting Hearings: If a license is suspended, not renewed, or revoked: The provider shall be entitled to a hearing preceding the effective date of the denial, suspension, non-renewal, or revocation if requested in writing within 21 days after receipt of notice. If no timely written request is received, the notice shall become the final order by default and the Chief Officer may designate the Division file as the record for purposes of order by default.

(2) Contested Case Hearings: Programs that wish to contest the suspension, non-renewal, or revocation of their license shall have an opportunity for a hearing by the Division according to the Attorney General's Model Rules of Procedure.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 430.397, 430.010-030, 430.306, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

415-012-0090
Variance or Exception

(1) Procedure for Submission of Request. Request must be made in writing:

(a) For an initial application it should be included with the application documents;

(b) If the provider is an agency under contract with the local mental health authority, it must submit the request through the local mental health authority to the Chief Officer; and

(b) If the provider is not under contract to the local mental health authority, the request should be submitted directly to the Chief Officer.

(2) Substance of Request: The request should include the following:

(a) The reason for the proposed variance or exception;

(b) The alternative practice proposed; and

(c) For an exception, a plan and timetable for compliance with the section of the rule from which the exception is sought.

(3) Approval or Denial: The Chief Officer, whose decision shall be final, shall approve or deny the request for variance or exception.

(4) Notification: The Division shall notify the provider requesting the variance or exception and the community mental health program of the decision.

(5) Variance Part of License: A variance granted by the Division shall be attached to, and become part of, the LOA or license. Continuance of the variance shall be reviewed at the time the license is considered for renewal.

Stat. Auth.: ORS 430.256
Stats. Implemented: ORS 430.010-030, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: ADAP 2-1993, f. & cert. ef. 11-5-93; ADS 2-2008, f. & cert. ef. 11-13-08; ADS 4-2013, f. & cert. ef. 5-3-13; ADS 2-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Permanent repeals to OAR 415-060 regarding the reduction of tabacco use by minors.
Adm. Order No.: ADS 3-2016
Filed with Sec. of State: 7-13-2016
Certified to be Effective: 7-13-16
Notice Publication Date: 5-1-2016
Rules Repealed: 415-060-0010, 415-060-0020, 415-060-0030, 415-060-0040, 415-060-0050
Subject: The purpose of these rules is to adopt procedures concerning random and targeted inspections of outlets which sell tobacco products consistent with Section 202, PL 102-321, (1992) 106stat.394-95, codified at 42 USC 300x-26, which requires enforcement of laws to reduce tobacco use by minors as a condition of full block grant funding.
Rules Coordinator: Nola Russell—(503) 945-7652

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Oregon Health Authority, Health Systems Division: Medical Assistance Programs
Chapter 410

Rule Caption: Amending Prior Authorization Approval Criteria Guide

Adm. Order No.: DMAP 26-2016
Filed with Sec. of State: 6-24-2016
Certified to be Effective: 6-28-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-121-0040
Rules Repealed: 410-121-0040(T)
Subject: The Pharmaceutical Services Program administrative rules (Division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows: The Authority is amending this rule to update the Oregon Medicaid Fee for Service Prior Authorization Criteria Guide found at http://www.oregon.gov/oha/healthplan/Pages/pharmacy-policy.aspx based on the P&T (Pharmacy and Therapeutic) Committee recommendations.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-121-0040
Prior Authorization Required for Drugs and Products

(1) Prescribing practitioners shall obtain prior authorization (PA) for the drugs and categories of drugs requiring PA in this rule, using the procedures set forth in OAR 410-121-0060.

(2) All drugs and categories of drugs including, but not limited to, those drugs and categories of drugs that require PA shall meet the following requirements for coverage:

(a) Each drug shall be prescribed for conditions funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services (OAR 410-141-0480 through 410-141-0520). If the medication is for a non-covered diagnosis, the medication may not be covered unless there is a co-morbid condition for which coverage would be allowed. The use of the medication shall meet corresponding treatment guidelines and be included within the client's benefit package of covered services and not otherwise excluded or limited;

(b) Each drug shall also meet other criteria applicable to the drug or category of drug in these pharmacy provider rules, including PA requirements imposed in this rule.

(3) The Authority may require PA for individual drugs and categories of drugs to ensure that the drugs prescribed are indicated for conditions funded by OHP and consistent with the Prioritized List of Health Services and its corresponding treatment guidelines (see OAR 410-141-0480). The drugs and categories of drugs that the Authority requires PA for this purpose are found in the Oregon Medicaid Fee-for-Service Prior Authorization Approval Criteria (PA Criteria guide) dated May 1, 2016, adopted and incorporated by reference and found at: http://www.oregon.gov/OHA/healthplan/pages/pharmacy-policy.aspx.

(4) The Authority may require PA for individual drugs and categories of drugs to ensure medically appropriate use or to address potential client safety risk associated with the particular drug or category of drug, as recommended by the Pharmacy & Therapeutics Committee (P&T) and adopted by the Authority in this rule. The drugs and categories of drugs for which the Authority requires PA for this purpose are found in the Pharmacy PA Criteria Guide.

(5) New drugs shall be evaluated when added to the weekly upload of the First Databank drug file:

(a) If the new drug is in a class where current PA criteria apply, all associated PA criteria shall be required at the time of the drug file load;

(b) If the new drug is indicated for a condition below the funding line on the Prioritized List of Health Services, PA shall be required to ensure that the drug is prescribed for a condition funded by OHP;

(c) PA criteria for all new drugs shall be reviewed by the DUR/P&T Committee.

(6) PA shall be obtained for brand name drugs that have two or more generically equivalent products available and that are not determined Narrow Therapeutic Index drugs by the DUR/P&T Committee:

(a) Immunosuppressant drugs used in connection with an organ transplant shall be evaluated for narrow therapeutic index within 180 days after United States patent expiration;

(b) Manufacturers of immunosuppressant drugs used in connection with an organ transplant shall notify the Authority of patent expiration within 30 days of patent expiration for section (5)(a) to apply;

(c) Criteria for approval are:

(A) If criteria established in section (3) or (4) of this rule applies, follow that criteria;

(B) If section (6)(A) does not apply, the prescribing practitioner shall document that the use of the generically equivalent drug is medically contraindicated and provide evidence that either the drug has been used and has failed or that its use is contraindicated based on evidence-based peer reviewed literature that is appropriate to the client's medical condition.

(7) PA shall be obtained for non-preferred Preferred Drug List (PDL) products in a class evaluated for the PDL except in the following cases:

(a) The drug is a mental health drug as defined in OAR 410-121-0000;

(b) The original prescription is written prior to 1/1/10;

(c) The prescription is a refill for the treatment of seizures, cancer, HIV, or AIDS; or

(d) The prescription is a refill of an immunosuppressant.

(8) PA may not be required:

(a) When the prescription ingredient cost plus the dispensing fee is less than the PA processing fees as determined by the Authority;

(b) For over-the-counter (OTC) covered drugs when prescribed for conditions covered under OHP; or

(c) If a drug is in a class not evaluated from the Practitioner-Managed Prescription Drug Plan under ORS 414.334.

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.330 to 414.414, 414.312 & 414.316
Stats. Implemented: 414.065, 414.334, 414.361, 414.371, 414.353 & 414.354
Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 2-1990, f. & cert. ef. 1-16-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0170; HR 10-1991, f. & cert. ef. 2-19-91; HR 14-1993, f. & cert. ef. 7-2-93; HR 25-1994, f. & cert. ef. 7-1-94; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 18-1996(Temp), f. & cert. ef. 10-1-96; HR 8-1997, f. 3-13-97, cert. ef. 3-15-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2002, f. & cert. ef. 10-1-02; OMAP 66-2002, f. 10-31-02, cert. ef. 11-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 87-2003(Temp), f. & cert. ef. 12-15-03 thru 5-15-04; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 71-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 74-2004, f. 9-23-04, cert. ef. 10-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 4-2006(Temp), f. & cert. ef. 3-15-06 thru 9-7-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 41-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 9-2008, f. 3-31-08, cert. ef. 4-1-08; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 14-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 27-2011(Temp), f. & cert. ef. 9-30-11 thru 3-15-12; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 18-2012, f. 3-30-12, cert. ef. 4-9-12; DMAP 23-2012(Temp), f. & cert. ef. 4-20-12 thru 10-15-12; DMAP 27-2012(Temp), f. & cert. ef. 5-14-12 thru 10-15-12; DMAP 29-2012, f. & cert. ef. 6-21-12; DMAP 33-2012(Temp), f. 7-18-12, cert. ef. 7-23-12 thru 1-18-13; DMAP 40-2012(Temp), f. & cert. ef. 8-20-12 thru 1-18-13; DMAP 44-2012(Temp), f. & cert. ef. 9-26-12 thru 1-18-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 6-2013(Temp), f. & cert. ef. 2-21-13 thru 8-19-13; DMAP 23-2013(Temp), f. 4-30-13, cert. ef. 5-1-13 thru 8-19-13; Administrative correction, 7-18-13; DMAP 43-2013, f. & cert. ef. 8-16-13; DMAP 76-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 14-2014(Temp), f. & cert. ef. 3-21-14 thru 9-17-14; DMAP 27-2014(Temp), f. & cert. ef. 5-2-14 thru 6-30-14; DMAP 38-2014, f. & cert. ef. 6-30-14; DMAP 46-2014(Temp), f. & cert. ef. 7-15-14 thru 1-11-15; DMAP 49-2014(Temp), f. & cert. ef. 8-13-14 thru 1-11-15; DMAP 62-2014(Temp), f. 10-13-14, cert. ef. 10-14-14 thru 1-11-15; DMAP 75-2014, f. & cert. ef. 12-12-14; DMAP 76-2014(Temp), f. & cert. ef. 12-12-14 thru 6-7-15; DMAP 89-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-26-15; DMAP 4-2015(Temp), f. & cert. ef. 2-3-15 thru 6-26-15; DMAP 25-2015(Temp), f. 4-17-15, cert. ef. 4-18-15 thru 6-26-15; DMAP 34-2015, f. 6-25-15, cert. ef 6-26-15; DMAP 36-2015(Temp), f. 6-26-15, cert. ef. 7-1-15 thru 12-27-15; DMAP 41-2015(Temp), f. & cert. ef. 8-7-15 thru 2-2-16; DMAP 44-2015(Temp), f. 8-21-15, cert. ef. 8-25-15 thru 12-27-15; DMAP 58-2015(Temp), f. & cert. ef. 10-9-15 thru 12-27-15; DMAP 80-2015, f. 12-23-15, cert. ef. 12-27-15; DMAP 83-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 6-2016(Temp), f. 2-11-16, cert. ef. 2-12-16 thru 6-28-16; DMAP 19-2016(Temp), f. 4-28-16, cert. ef. 5-1-16 thru 6-28-16; DMAP 26-2016, f. 6-24-16, cert. ef. 6-28-16

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Rule Caption: Amending PDL November 19, 2015, January 28, 2016 DUR/P&T Action
Adm. Order No.: DMAP 27-2016
Filed with Sec. of State: 6-24-2016
Certified to be Effective: 6-28-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-121-0030
Rules Repealed: 410-121-0030(T)
Subject: The Pharmaceutical Services Program administrative rules (Division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

410-121-0030:
Preferred:
Budesonide
Exenatide Pen Injector
Guaifenesin (Mucinex™)
Daclatasvir Dihydrochloride
Elviteg/ Cobi/ Emtric/ Tenofo Ala (Genvoya™)

Rivaroxaban (Xarelto™)
Insulin Lispro Protamin / Lispro
Non-Preferred:
Ciclesonide Nasal Spray/ Pump
Ombita/ Paritap/ Riton/ Dasabuvir (Viekira Pak™)
Amantadine HCL
Rimantadine HCL
Bupropion HCL
Amphetamine Sulfate
Tobramycin
TOBI

Due to changes in supplemental rebate contracts, the following changes were made:

Removed Pegasys™
Added Sovaldi™
Added Evotaz™
Added Eliquis™
Added Pradaxa™
Removed Androgel™
Added Janumet™
Removed Humalog™
Removed Humalog Mix 50/50™
Removed Humalog Mix 75/25™
Removed Humulin R™
Removed Humulin N™
Removed Humulin 70/30™
Removed Makena™
Removed Apriso™
Removed Exelon™
Removed Capaxone™
Removed Avonex™
Removed Betaseron™
Removed Stalevo™
Removed Zubsolv™
Removed Bethkis™
Added Renagel™

Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-121-0030
Practitioner-Managed Prescription Drug Plan

(1) The Practitioner-Managed Prescription Drug Plan (PMPDP) is a plan that ensures that OHP fee-for-service clients have access to the most effective prescription drugs appropriate for their clinical conditions at the best possible price:

(a) Licensed health care practitioners, who are informed by the latest peer reviewed research, make decisions concerning the clinical effectiveness of the prescription drugs;

(b) Licensed health care practitioners also consider the client's health condition, personal characteristics, and the client's gender, race, or ethnicity.

(2) PMPDP Preferred Drug List (PDL):

(a) The PDL is the primary tool the Division uses to inform licensed health care practitioners about the results of the latest peer-reviewed research and cost effectiveness of prescription drugs;

(b) The PDL contains a list of prescription drugs that the Division, in consultation with the Drug Use Review (DUR)/Pharmacy & Therapeutics Committee (P&T), has determined represent the most effective drugs available at the best possible price;

(c) The PDL shall include drugs that are Medicaid reimbursable and the Food and Drug Administration (FDA) has determined to be safe and effective.

(3) PMPDP PDL Selection Process:

(a) The Division shall utilize the recommendations made by the P&T that result from an evidence-based evaluation process as the basis for selecting the most effective drugs;

(b) The Division shall ensure the drugs selected in section (3)(a) that are available for the best possible price and shall consider any input from the P&T about other FDA-approved drugs in the same class that are available for a lesser relative price. The Division shall determine relative price using the methodology described in section (4);

(c) The Division shall evaluate selected drugs for the drug classes periodically:

(A) The Division may evaluate more frequently if new safety information or the release of new drugs in a class or other information makes an evaluation advisable;

(B) New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T;

(C) The Division shall make all revisions to the PDL using the rule-making process and shall publish the changes on the Division's Pharmaceutical Services provider rules website.

(4) Relative cost and best possible price determination:

(a) The Division shall determine the relative cost of all drugs in each selected class that are Medicaid reimbursable and that the FDA has determined to be safe and effective;

(b) The Division may also consider dosing issues, patterns of use, and compliance issues. The Division shall weigh these factors with any advice provided by the P&T in reaching a final decision.

(5) Pharmacy providers shall dispense prescriptions in the generic form unless:

(a) The practitioner requests otherwise pursuant to OAR 410-121-0155;

(b) The Division notifies the pharmacy that the cost of the brand name particular drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug.

(6) The exception process for obtaining non-preferred physical health drugs that are not on the PDL drugs shall be as follows:

(a) If the prescribing practitioner in their professional judgment wishes to prescribe a physical health drug not on the PDL, they may request an exception subject to the requirements of OAR 410-121-0040;

(b) The prescribing practitioner must request an exception for physical health drugs not listed in the PDL subject to the requirements of OAR 410-121-0060;

(c) Exceptions shall be granted when:

(A) The prescriber in their professional judgment determines the non-preferred drug is medically appropriate after consulting with the Division or the Oregon Pharmacy Call Center; or

(B) Where the prescriber requests an exception subject to the requirement of section (6)(b) and fails to receive a report of PA status within 24 hours, subject to OAR 410-121-0060.

(7) Table 121-0030-1, PMPDP PDL dated July 1, 2016 is adopted and incorporated by reference and is found at: www.orpdl.org.

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

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.325, 414.330 to 414.414, 414.312 & 414.316

Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369, 414.371, 414.353 & 414.354

Hist.: OMAP 25-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 31-2002, f. & cert. ef. 8-1-02; OMAP 36-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 35-2003, f. & cert. ef. 5-1-03; OMAP 47-2003, f. & cert. ef. 7-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 70-2003(Temp), f. 9-15-03, cert. ef. 10-1-03 thru 3-15-04; OMAP 82-2003, f. 10-31-03, cert. ef. 11-1-03; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 29-2004, f. 4-23-04 cert. ef. 5-1-04; OMAP 34-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 45-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 81-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 32-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 58-2005, f. 10-27-05, cert. ef. 11-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 48-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 2-2011(Temp), f. & cert. ef. 3-1-11 thru 8-20-11; DMAP 19-2011, f. 7-15-11, cert. ef. 7-17-11; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 18-2012, f. 3-30-12, cert. ef. 4-9-12; DMAP 26-2012, f. & cert. ef. 5-14-12; DMAP 29-2012, f. & cert. ef. 6-21-12; DMAP 33-2012(Temp), f. 7-18-12, cert. ef. 7-23-12 thru 1-18-13; DMAP 40-2012(Temp), f. & cert. ef. 8-20-12 thru 1-18-13; DMAP 44-2012(Temp), f. & cert. ef. 9-26-12 thru 1-18-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 6-2013(Temp), f. & cert. ef. 2-21-13 thru 8-19-13; DMAP 23-2013(Temp), f. 4-30-13, cert. ef. 5-1-13 thru 8-19-13; Administrative correction, 7-18-13; DMAP 43-2013, f. & cert. ef. 8-16-13; DMAP 76-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 1-2014(Temp), f. & cert. ef. 1-10-14 thru 7-9-14; DMAP 15-2014, f. & cert. ef. 3-21-14 thru 9-17-14; DMAP 28-2014(Temp), f. & cert. ef. 5-2-14 thru 6-30-14; DMAP 37-2014, f. & cert. ef. 6-30-14; DMAP 47-2014(Temp), f. & cert. ef. 7-15-14 thru 1-11-15; DMAP 52-2014(Temp), f. & cert. ef. 9-16-14 thru 1-11-15; DMAP 64-2014(Temp), f. 10-24-14, cert. ef. 10-29-14 thru 12-30-14; DMAP 77-2014, f. & cert. ef. 12-12-14; DMAP 78-2014(Temp), f. & cert. ef. 12-12-14 thru 6-9-15; DMAP 88-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 10-2015(Temp), f. & cert. ef. 3-3-15 thru 8-29-15; DMAP 26-2015(Temp), f. 4-17-15, cert. ef. 4-18-15 thru 6-26-15; DMAP 35-2015, f. 6-25-15, cert. ef. 6-26-15; DMAP 37-2015(Temp), f. & cert. ef. 7-1-15 thru 12-27-15; DMAP 57-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 12-27-15; DMAP 64-2015(Temp), f. & cert. ef. 11-3-15 thru 12-27-15; DMAP 66-2015(Temp), f. & cert. ef. 11-6-15 thru 12-27-15; DMAP 79-2015, f. 12-22-15, cert. ef. 12-27-15; DMAP 84-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 18-2016(Temp), f. 4-28-16, cert. ef. 5-1-16 thru 6-28-16; DMAP 27-2016, f. 6-24-16, cert. ef. 6-28-16

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Rule Caption: Timeframes for Seeing, Referring or Providing Services to OHP Fee-for-Service Pregnant Clients

Adm. Order No.: DMAP 28-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-28-16
Notice Publication Date: 6-1-2016
Rules Adopted: 410-123-1510
Rules Repealed: 410-123-1510(T)
Subject: The rule implements Sections 2 and 4 of House Bill 3464, which passed in 2015. It creates a standard for access to dental care for pregnant women who receive Oregon Health Plan benefits through the fee-for-service delivery system that is as good as or better than the standard for clients who receive benefits through the managed care delivery system, as measured by how long it takes for a client to receive a dental appointment.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-123-1510
Dental Care Access Standards for Pregnant Women

(1) This rule sets forth the access standards for dental care for pregnant women who receive Oregon Health Plan (OHP) benefits through the fee-for-service delivery system.

(2) Pregnant clients must be seen, treated, or referred to an OHP-covered service within the following time frames:

(a) For emergency dental care: within 24 hours;

(b) For urgent dental care: one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060;

(c) For routine dental care: an average of four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate;

(d) For initial dental screening or examination: four weeks.

(3) Nothing in this rule obligates a pregnant woman who receives dental care through the fee-for-service delivery system to accept an offered appointment.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: DMAP 82-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 28-2016, f. & cert. ef. 6-28-16

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Rule Caption: Amend CCO Enrollment and Disenrollment Rules Aligning Current Practices and Pregnancy Enrollment Exemption Processes
Adm. Order No.: DMAP 29-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-28-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-141-3060, 410-141-3080
Rules Repealed: 410-141-3060(T), 410-141-3080(T)
Subject: The Division is amending OAR 410-141-3060 and 410-141-3080 to align these CCO rules reflecting current enrollment and disenrollment practices and to update them as they relate to the most recent pregnancy enrollment exemption protocols.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-3060
Enrollment Requirements in a CCO

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

(a) "Client" means an individual found eligible to receive OHP health services;

(b) "Eligibility Determination" means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) "Member" means a client enrolled with a pre-paid health plan or a coordinated care organization as stated in OAR 410-120-0000;

(d) "Newly Eligible" means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) "Renewal", as stated in OAR 410-200-0015, means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) Pursuant to ORS 414.631, the following populations may not be enrolled into a CCO for any type of health care coverage including:

(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;

(c) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(3) The following populations may not be enrolled into a CCO under the following circumstances:

(a) Newly eligible clients are exempt from enrollment with a CCO but not exempt from enrollment in a DCO if they became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client. The individual shall receive dental services through the DCO;

(b) The client is covered under a major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a PHP as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.

(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt mandatory enrollment into a managed care plan, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) Populations specified below are exempt from mandatory enrollment into a physical health CCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member's service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These populations are as follows:

(a) Children in the legal custody of the Department or 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 FFS basis is not available; or

(B) Enrollment would preserve continuity of care.

(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these:

(A) A client has the option to 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, has the option to enroll in a CCO even if the CCO does not have a corresponding Medicare Advantage plan;

(C) A client has the option to 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 has the option to enroll with a CCO even if the client is enrolled in Medicare Advantage with another entity.

(6) The Authority may 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 for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. 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) Separate from requirements in 410-141-3080, (3)(c)(A), a pregnant women at any point prior to the end of the twenty-seventh week and sixth day of pregnancy who meets the qualifications in sub-sections A through E below may receive OHP benefits on a FFS basis for physical health only, until 60 days post estimated date of delivery. Women receiving services FFS for their physical health plan coverage shall continue to be enrolled in the appropriate CCO plan in their service area for dental and mental health coverage. Sixty days after the estimated date of delivery, the member shall re-enroll in a plan as appropriate. Qualifying criteria are as follows:

(A) Be pregnant;

(B) Have an established relationship with a licensed, practitioner who is not a participating provider with the client's CCO;

(C) Make a request to change to FFS. This request can be made through the end of the twenty-seventh week and sixth day of pregnancy;

(D) Meet all relevant state and federal rules;

(E) If a woman becomes unable to meet the requirements, the exemption shall be withdrawn and the client shall be subject to CCO enrollment requirements as stated in OAR 410-141-3060.

(c) The following apply to clients and exemptions relating to organ transplants:

(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;

(B) Newly eligible clients with existing transplants shall enroll into the appropriate CCO for their service area.

(d) Other just causes to preserve continuity of care include the following considerations:

(A) Enrollment would pose a serious health risk; and

(B) The Authority finds no reasonable alternatives.

(7) Unless stated above, CCO enrollment is mandatory in all areas served by a CCO. A client who is eligible for or receiving health services shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4) and (5) and this rule.

(8) Enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP.

(9) Enrollment is mandatory in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. If upon application or redetermination a client does not select a CCO, the Authority shall auto-assign the client and the client's household to a CCO that has adequate health care access and capacity. The following outlines the priority of enrollment in service areas where enrollment is mandatory and a PHP remains available for enrollment:

(a) Priority 1: The client shall enroll in a CCO that serves that area and has adequate health care access and capacity;

(b) Priority 2: The client has the option to enroll in a PHP through a manual process if:

(A) The client has an established relationship with a provider who is only contracted with the PHP; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members. Clients shall be FFS unless already established with a PHP's provider.

(c) Priority 3: The client shall receive services on an FFS basis.

(10) If a service area changes from mandatory 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 410-141-3080.

(11) Clients who are exempt from physical health services or who are enrolled with a PHP for physical health services shall receive managed or coordinated mental health and oral health services as follows:

(a) The client shall be enrolled with a CCO if the CCO offers mental health and oral health services; or

(b) The client shall be enrolled with an MHO for mental health services and with a DCO for oral health services if the CCO does not offer those services; or

(c) The client shall be enrolled with a DCO for oral health services and remain FFS for mental health services if an MHO is not available; or

(d) The client shall remain FFS for both mental health and oral health services if an MHO or DCO is unavailable.

(12) 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.

(13) Coordinated care services shall begin as of the effective date 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 persons other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

(c) For members who are re-enrolled within 60 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above;

(d) 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 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 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; DMAP 65-2013, f. & cert. ef. 11-29-13; DMAP 35-2014(Temp), f. 6-25-14, cert. ef. 7-1-14 thru 12-27-14; DMAP 69-2014(Temp), f. 12-8-14, cert. ef. 12-27-14 thru 12-31-14; DMAP 70-2014, f. 12-8-14, cert. ef. 1-1-15; DMAP 72-2014(Temp), f. 12-9-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 8-2015, f. 2-26-15, cert. ef. 3-1-15; DMAP 56-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 2-4-16; DMAP 72-2015(Temp), f. 12-18-15, cert. ef. 1-1-16 thru 6-28-16; Administrative correction, 12-24-16; DMAP 29-2016, f. & cert. ef. 6-28-16

410-141-3080

Disenrollment from Coordinated Care Organizations

(1) Continuity of care, for purpose of this rule, means the ability to sustain services necessary for a person's treatment. Continuity of care is a concern when a member is transferred from one service provider to another.

(2) All member-initiated requests for disenrollment from a Coordinated Care Organization (CCO) shall be initiated orally or in writing by the primary person in the benefit group enrolled with a CCO where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative.

(3) In accordance with 42 CFR 438.56(c)(2), the Authority or CCO shall honor a member or representative request for disenrollment for the following:

(a) Without cause:

(A) Clients may request to change their CCO enrollment within 30 days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle;

(B) Clients may request to change their CCO enrollment within 90 days of the initial CCO enrollment. If approved, the change would occur during the next weekly enrollment cycle;

(C) Clients may request to change their CCO enrollment after they have been enrolled with a plan for at least six months. If approved, the change would occur during the end of the month;

(D) Clients may request to change their CCO enrollment or upon OHP eligibility renewal, as defined in OAR 410-141-3060. The OHP eligibility period is typically 12 months. If approved, the change would occur during the end of the month;

(E) Clients have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. The plan change shall be considered "recipient choice." If approved, the change would occur at the end of the month. Once the recipient choice option has been applied, the client must be enrolled with the same plan at least six months or until the OHP eligibility renewal, whichever comes first, to request an additional plan change.

(b) With cause:

(A) At any time;

(B) Due to moral or religious objections, the CCO does not cover the service the member seeks;

(C) When 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

(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the member's health care needs. Examples of sufficient cause include, but are not limited to:

(i) The member moves out of the CCO service area;

(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;

(iii) Continuity of care that is not in conflict with any section of OAR 410-141-3060, or as defined in this rule. Participation in OHP, including coordinated care or dental care, does not guarantee that any OHP member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of an OHP member or a provider of a treatment, service, or supply, including, but not limited to, a decision of a provider to participate or decline to participate in a CCO;

(iv) As specified in ORS 414.647, the Authority may approve the transfer of 500 or more members from one CCO to another CCO if:

(I) The member's provider has contracted with the receiving CCO and has stopped accepting patients from or has terminated providing services to members in the transferring CCO; and

(II) Members are offered the choice of remaining enrolled in the transferring CCO; and

(III) The member and all family (case) members shall be transferred to the provider's new CCO; and

(IV) The transfer shall take effect when the provider's contract with their current CCO contractual relationship ends, or on a date approved by the Division; and

(V) Members may not be transferred under section (2)(E)(vi) until the Division has evaluated the receiving CCO and determined that the CCO meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the CCO maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and

(VI) The Division shall provide notice of a transfer to members affected by the transfer at least 90 days before the scheduled date of the transfer.

(E) If a member's disenrollment is denied, notice of denial shall be sent to the member pursuant to OAR 410-141-0263 and 410-141-3263 of their right to file a grievance or request a hearing.

(c) If the following conditions are met:

(A) As supported in 42 CFR 438.56(d)(2), if a client is at any point in the third trimester of pregnancy and if the client is newly determined eligible for OHP, or the client is newly re-determined eligible for OHP and not enrolled in a CCO within the past three months; or

(B) If the member is enrolled with a new CCO that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider;

(C) The enrollment exemption shall remain in place until 60 days post date of delivery of the member's child, at which time the member shall select and be enrolled in the appropriate CCO plan in their service area.

(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:

(A) Transfer of a member from a PHP to a CCO;

(B) Involuntary transfer of a member from a CCO to another CCO; or

(C) Automatic enrollment of a member in a CCO.

(e) Member disenrollment requests are subject to the following requirements:

(A) The member shall join another CCO unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment set forth in OAR 410-141-3060 or 410-141-0060, or the member meets disenrollment criteria stated in 42 CFR 438.56(c)(2), or there is not another CCO in the service area;

(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;

(C) If the Authority fails to make a disenrollment determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.

(4) The CCO may not disenroll members solely for the following reasons:

(a) Because of a physical, intellectual, developmental, or mental disability;

(b) Because of an adverse change in the member's health;

(c) Because of the member's utilization of services, either excessive or lack thereof;

(d) Because the member requests a hearing;

(e) Because the member exercises their option to make decisions regarding their medical care with which the CCO disagrees;

(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.

(5) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the CCO requests it for cause, which includes, but is not limited to, the following:

(a) The member commits fraudulent or illegal acts related to the member's participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The CCO shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 888-Fraud01 (888-372-8301) or http://www.oregon.gov/DHS/aboutdhs/fraud/ as appropriate, consistent with 42 CFR 455.13;

(b) The member became eligible through a hospital hold process and placed in the Adults and Couples category as required under OAR 410-141-3060;

(c) Requests by the CCO for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:

(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The CCO shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below shall be followed and documented prior to requesting disenrollment of a member;

(B) There shall be notification from the provider to the CCO at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the CCO. Such notification shall be documented in the member's clinical record. The CCO shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;

(C) The CCO shall contact the member either verbally or in writing, if it is a severe problem, to inform the member of the problem that has been identified and attempt to develop an agreement with the member regarding the issue. Any contact with the member shall be documented in the member's clinical record. The CCO shall inform the member that their continued behavior may result in disenrollment from the CCO;

(D) The CCO shall provide individual education, disability accommodation, counseling, or other interventions with the member in a serious effort to resolve the problem;

(E) The CCO shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution within the laws governing confidentiality;

(F) If the severity of the problem warrants, the CCO shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the CCO shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;

(G) The CCO shall submit any additional information or assessments requested by the Division CAR;

(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;

(I) If the member's behavior is uncooperative or disruptive including, but not limited to, threats or acts of physical violence as the result of his or her special needs or disability, the CCO shall also document each of the following:

(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the CCO shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others shall actually occur; and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;

(ii) A CCO -staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;

(iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;

(iv) Documentation of any accommodations that have been attempted and why the accommodations haven't worked;

(v) Documentation of the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either this particular member or other members;

(vi) If a Primary Care Provider (PCP) terminates the provider/patient relationship, the CCO shall attempt to locate another PCP on their panel who shall accept the member as their patient. If needed, the CCO shall obtain an authorization for release of information from the member in order

to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be according to the CCO's policies and shall be consistent with CCO or PCP's policies for commercial members and with applicable disability discrimination laws. The CCO shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.

(d) In addition to the requirements in subsection (c), requests by the CCO for an exception to the routine disenrollment process shall include the following:

(A) In accordance with 42 CFR 438.56, the CCO shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the CCO's staff so that it seriously impairs the CCO's ability to furnish services to either this particular member or other members. A credible threat means that there is a significant risk that the member may cause grievous physical injury to others (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. The CCO shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an exception to the disenrollment process of a member;

(B) Providers shall immediately notify the CCO about the incident with the member. The notification shall describe the problem and be maintained for documentation purposes;

(C) The CCO shall attempt and document contact with the member and their care team regarding the problem and, if needed, involve the care team and other appropriate individuals in the resolution within the laws governing confidentiality;

(D) The CCO shall provide any additional information requested by the CAR, the Authority, or the Department assessment team;

(E) If the member's behavior could reasonably be perceived as the result of their special needs or disability, the CCO shall also document each of the following:

(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined in section (2)(b)(C)(i) of this rule;

(ii) In determining whether a member poses a credible threat to the health or safety of others, the CCO shall make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others may actually occur; and whether reasonable modifications of policies, practices, or procedures may mitigate the risk to others.

(F) Documentation shall exist that verifies the provider or CCO immediately reported the incident to law enforcement. The CCO shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinical record documenting the report to law enforcement or other reasonable evidence;

(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures may not mitigate the risk to others;

(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;

(I) Documentation shall exist that verifies the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either this particular member or other members.

(e) Approval or denial of disenrollment requests shall include the following:

(A) If there is sufficient documentation, the request shall be evaluated by the CCO's CAR or a team of CARs who may request additional information from Ombudsman Services, AMH, or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the AMH's substance use disorder specialist;

(B) In cases where the member is also enrolled in the CCO's Medicare Advantage plan, the CCO shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;

(C) If there is insufficient documentation, the CAR shall notify the CCO within two business days of initial receipt what supporting documentation is needed for final consideration of the request;

(D) The CARs shall review the request and notify the CCO of the decision within ten working days of receipt of sufficient documentation from the CCO;

(E) Written decisions shall be sent to the CCO within 15 working days from receipt of request and sufficient documentation from the CAR.

(6) The following procedures apply to all denied disenrollment requests:

(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the CCO and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint, as specified in 410-141-3260 through 410-141-3266, and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;

(c) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO;

(d) If no other CCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO again requests disenrollment for cause, the request shall be referred to the Authority assessment team for review.

(7) The following procedures apply to all approved disenrollment requests:

(a) The CAR shall send the member a notice within five days after the request was approved with a copy to the CCO and the member's care team;

(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of member's right to file a complaint, as specified in OAR 410-141-3260 through 410-141-3266, and to request an administrative hearing and the option to continue enrollment in the CCO pending the outcome of the hearing, in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;

(c) The disenrollment effective date shall be ten calendar days after the disenrollment notice is sent to the member, unless the member requests a hearing and ongoing enrollment pending a hearing decision. The disenrollment shall become effective immediately upon the issuing of an Administrative Law Judge's decision to uphold disenrollment;

(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO;

(e) If no other CCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO or the member again requests disenrollment for cause, the request shall be referred to the Authority's assessment team for review.

(8) Other reasons for the CCO's requests for disenrollment may include the following:

(a) If the member is enrolled in the CCO on the same day the member is admitted to the hospital, the CCO shall be responsible for the hospitalization. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services;

(b) The member has surgery scheduled at the time their enrollment is effective with the CCO, the provider is not on the CCO's provider panel, and the member wishes to have the services performed by that provider;

(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the CCO;

(d) If the CCO determines the member has Third Party Liability (TPL), the CCO shall report the TPL to the Health Insurance Group (HIG) at www.reportTPL.org.HIG and send the CCO an email receipt, including a tracking number. The CCO may use this number, should they choose to

follow up on their referral submission, via the provider portal. If the member is determined to have active TPL, HIG shall disenroll the member from the CCO A or B, effective the end of the month the TPL is reported, as referenced above, and the member is not reflected on that month's 834 report;

(e) If a CCO has knowledge of a member's change of address, the CCO shall notify the member's care team. The care team shall verify the address information and disenroll the member from the CCO if the member no longer resides in the CCO's service area. Members shall be disenrolled if out of the CCO's service area for more than three months unless previously arranged with the CCO or DCO. The effective date of disenrollment shall be the date specified by the Division, and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the CCO;

(f) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The CCO shall identify the members and provide sufficient proof of incarceration to the Division for review of the disenrollment request. The Division shall approve requests for disenrollment from CCO's for members who have been taken into custody;

(g) The member is in a state psychiatric institution.

(9) The Division may initiate and disenroll members as follows:

(a) If informed that a member has TPL, the Division shall refer the case to the HIG for investigation and possible exemption from CCO enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;

(b) If the member moves out of the CCO's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the CCO;

(c) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Division;

(d) If the member dies, the last date of enrollment shall be the date of death.

(10) Unless specified otherwise in these rules or in the Division notification of disenrollment to the CCO, all disenrollments are effective the end of the month the Authority approves the disenrollment with the following exceptions:

(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated;

(b) The Authority may retroactively disenroll the member if they have TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

Stat. Auth.: ORS 413.032, 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; DMAP 65-2013, f. & cert. ef. 11-29-13; DMAP 8-2014(Temp), f. 1-31-14, cert. ef. 2-1-14 thru 7-31-14; DMAP 30-2014, f. 5-23-14, cert. ef. 6-1-14; DMAP 71-2015, f. & cert. ef. 12-10-15; DMAP 72-2015(Temp), f. 12-18-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 29-2016, f. & cert. ef. 6-28-16

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Rule Caption: Update International Classification of Diseases Coding from ICD-9 to ICD-10 and Name Changes
Adm. Order No.: DMAP 30-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-120-0000
Subject: Currently ICD-9 is the International Classification of Diseases that is used by providers to input diagnosis codes on claims. Effective October 1, 2015 the coding will change to ICD-10. The Authority needs to amend and update these rules to reflect the change to ICD-10. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services. Changing Division of Medical Assistance Programs to Health Systems Division.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

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), Health Systems Division (Division) 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; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411 or 413 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) "Action" means a termination, suspension, or reduction of eligibility or covered services. For the definition as it is related to a CCO member, refer to OAR 410-141-0000.

(3) "Acupuncturist" means a person licensed to practice acupuncture by the relevant state licensing board.

(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.

(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.

(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.

(7) "Addiction Division and Mental Health Division" means the Divisions within the Authority's Health Systems Division that administers mental health and addiction programs and services.

(8) "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.

(9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records, requested on the OHP 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.

(10) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.

(11) "Adverse Event" means an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

(12) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."

(13) "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.

(14) "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 individuals (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).

(15) "Alternative Care Settings" means 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.

(16) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured persons that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.

(17) "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).

(18) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.

(19) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and 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.

(20) "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).

(21) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.

(22) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.

(23) "Appeal" means a request for review of an action.

(24) "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.

(25) "Atypical Provider" means an entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

(26) "Audiologist" means a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(27) "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.

(28) "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.

(29) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

(30) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.

(31) "Behavioral Health Case Management" means services provide to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.

(32) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.

(33) "Benefit Package" means the package of covered health care services for which the client is eligible.

(34) "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.

(35) "Billing Provider (BP)" means a person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to 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.

(36) "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.)

(37) "By Report (BR)": means services designated, as BR requires 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.

(38) "Case Management Services" means 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 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 that may include referrals to Allied Agencies.

(39) "Certified Traditional Health Worker" means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.

(40) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.

(41) "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.

(42) "Chiropractor" means a person licensed to practice chiropractic by the relevant state licensing board.

(43) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.

(44) "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).

(45) "Claimant" means a person who has requested a hearing.

(46) "Client" means an individual found eligible to receive OHP health services.

(47) "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.

(48) "Clinical Social Worker" means a person licensed to practice clinical social work pursuant to state law.

(49) "Clinical Record" means the medical, dental, or mental health records of a client or member.

(50) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.

(51) "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.

(52) "Community Health Worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;

(f) Provides health education and information that is culturally appropriate to the individuals being served;

(g) Assists community residents in receiving the care they need;

(h) May give peer counseling and guidance on health behaviors; and

(i) May provide direct services such as first aid or blood pressure screening.

(53) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority's Addictions and Mental Health Division (AMH).

(54) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV); and treatments described in the Current Procedural Terminology, 4th edition (CPT-4); or American Dental Association Codes (CDT-2) or the Authority AMH Medicaid Procedure Codes and Reimbursement Rates, that, when paired by the Health Evidence Review

Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.

(55) "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.

(56) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.

(57) "Contiguous Area Provider" means a provider practicing in a contiguous area.

(58) "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.

(59) "Coordinated Care Organization (CCO)" as defined in OAR 410-141-0000.

(60) "Co-Payments" means 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.)

(61) "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.

(62) "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.

(63) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(64) "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.

(65) "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.

(66) "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.

(67) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.

(68) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(69) "Dental Services" means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.

(70) "Dentist" means a person licensed to practice dentistry pursuant to state law of the state in which he or 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.

(71) "Denturist" means a person licensed to practice denture technology pursuant to state law.

(72) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.

(73) "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.

(74) "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.

(75) "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.

(76) "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.

(77) "Department Representative" means a person who represents the Department and presents the position of the Department in a hearing.

(78) "Diagnosis Code" means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(79) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.

(80) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(81) "Division (Division)" means the Health Systems 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.

(82) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means 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.

(83) "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.

(84) "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.

(85) "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.

(86) "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.

(87) "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.

(88) "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)).

(89) "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.

(90) "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.

(91) "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)).

(92) "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.

(93) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.

(94) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that 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.

(95) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating 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.

(96) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(97) "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.

(98) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.

(99) "Health Care Interpreter" Certified or Qualified as defined in ORS 413.550.

(100) "Health Care Professionals" means 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.

(101) "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, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(102) "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.

(103) "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.

(104) "Health Maintenance Organization (HMO)" means a public or private health care organization that 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.

(105) "Health Plan New/non-categorical 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.

(106) "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.

(107) "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.

(108) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that 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.

(109) "Home Health Services" means 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.

(110) "Home Intravenous Services" means 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.

(111) "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.

(112) "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 is currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(113) "Hospital" means a facility licensed by the Office of Public Health Systems as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as 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.

(114) "Hospital-Based Professional Services" means 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.

(115) "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 or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(116) "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.

(117) "Indian Health Care Provider" means an Indian health program or an urban Indian organization.

(118) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.

(119) "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.

(120) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in 813.602(5).

(121) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(122) "Inpatient Hospital Services" means 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.)

(123) "Institutional Level of Income Standards (ILIS)" means 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 Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.

(124) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.

(125) "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(126) "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 and 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).

(127) "Laboratory Services" means 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 or 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.

(128) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.

(129) "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.

(130) "Long-Term Acute Care Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.

(131) "Managed Care Organization (MCO)" means a 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), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(132) "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 that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.

(133) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.

(134) "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.

(135) "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.

(136) "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).

(137) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.

(138) "Medical Transportation" means transportation to or from covered medical services.

(139) "Medically Appropriate" means services and medical supplies that are 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, 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 that can be safely provided to a Division client or CCO member in the Division or CCO's judgment.

(140) "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 that 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. It 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.

(141) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(142) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is 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.

(143) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(144) "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.

(145) "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.

(146) "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.

(147) "Naturopathic physician" means a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

(148) "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..

(149) "Non-covered Services" means 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.

(150) "Non-Emergent Medical Transportation Services (NEMT)"means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000(76) and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

(151) "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).

(152) "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.

(153) "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.

(154) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.

(155) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.

(156) "Nursing Services" means 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.

(157) "Nutritional Counseling" means counseling that takes place as part of the treatment of a person with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(158) "Occupational Therapist" means a person licensed by the State Board of Examiners for Occupational Therapy.

(159) "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, the 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.

(160) "Ombudsman Services" means 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.

(161) "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.

(162) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that 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

(163) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.

(164) "Optometrist" means a person licensed to practice optometry pursuant to state law.

(165) "Oregon Health Authority (Authority)" 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 Oregon Health Authority are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs.

(166) "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.

(167) "Out-of-State Providers" means 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.

(168) "Outpatient Hospital Services" means 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.

(169) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.

(170) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(171) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.

(172) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.

(173) "Panel" means the Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(174) "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.

(175) "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.

(176) "Peer Wellness Specialist" means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.

(177) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and will assist the patient in achieving the goals.

(178) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions, and desired outcome.

(179) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his or her scope of practice.

(180) "Pharmacist" means a person licensed to practice pharmacy pursuant to state law.

(181) "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.

(182) "Physical Therapist" means a person licensed by the relevant state licensing authority to practice physical therapy.

(183) "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 may not include radiology or electrosurgery.

(184) "Physician" means a person licensed to practice medicine pursuant to state law of the state in which he or 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 ORS 685.

(185) "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.

(186) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.

(187) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.

(188) "Podiatrist" means a person licensed to practice podiatric medicine pursuant to state law.

(189) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.

(190) "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 or certification.

(191) "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), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(192) "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.

(193) "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.

(194) "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.

(195) "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.

(196) "Private Duty Nursing Services" means 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.

(197) "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 unless otherwise specified.

(198) "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) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)

(199) "Public Health Clinic" means a clinic operated by a county government.

(200) "Public Rates" means 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.

(201) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.

(202) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.

(203) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.

(204) "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.

(205) "Radiological Services" means 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.

(206) "Recipient" means a person who is currently eligible for medical assistance (also known as a client).

(207) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(208) "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.

(209) "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.

(210) "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.

(211) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.

(212) "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.

(213) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

(214) "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.

(215) "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.

(216) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.

(217) "Sanction" means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.

(218) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

(219) "Self-Sufficiency" means the division in the Department of Human Services (Department) that administers programs for adults and families.

(220) "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.

(221) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indi-

gent and low-income individuals. The sliding-fee schedule is based on ability to pay.

(222) "Social Worker" means a person licensed by the Board of Clinical Social Workers to practice clinical social work.

(223) "Speech-Language Pathologist" means a person licensed by the Oregon Board of Examiners for Speech Pathology.

(224) "Speech-Language Pathology Services" means 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.

(225) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.

(226) "Subparts (of a Provider Organization)" means 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 and could be components of an organization or separate physical locations of an organization.

(227) "Subrogation" means right of the state to stand in place of the client in the collection of third party resources (TPR).

(228) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the American Society of Addiction Medicine Patient Placement Criteria 2-Revision (ASAM PPC-2R). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

(229) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.

(230) "Surgical Assistant" means a person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(231) "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.

(232) "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.

(233) "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.

(234) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.

(235) "Transportation" means medical transportation.

(236) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.

(237) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.

(238) "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.

(239) "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.

(240) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.

(241) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.

(242) "Urgent Care Services" means 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.

(243) "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 percent 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.

(244) "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.

(245) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:

(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).

(246) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:

(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and

(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.

(247) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

(248) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department 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; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 57-2014, f. 9-26-14, cert. ef. 10-1-14; DMAP 5-2015, f. & cert. ef. 2-10-15; DMAP 29-2015, f. & cert. ef. 5-29-15; DMAP 55-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 30-2016, f. 6-29-16, cert. ef. 7-1-16

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Rule Caption: Enroll and Reimburse Specialty Hospitals Classified as Long-Term Acute Care Hospitals
Adm. Order No.: DMAP 31-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016

Rules Amended: 410-120-0000, 410-125-0080, 410-125-0141, 410-125-0400

Subject: The Oregon Health Authority (Authority) is proposing to reimburse specialty hospitals classified as Long-Term Acute Care Hospitals (LTACH) that are eligible for reimbursement for services that meet the definition at 42CFR 440.10. LTACH furnish extended medical and rehabilitative care to individuals with clinically complex problems such as multiple acute or chronic conditions that need hospital-level care for relatively extended periods. To qualify as a LTACH for payment, a facility must meet Medicare's conditions of participation for acute care hospitals.

Rules Coordinator: Sandy Cafourek—(503) 945-6430

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), Health Systems Division (Division) 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; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411 or 413 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) "Action" means a termination, suspension, or reduction of eligibility or covered services. For the definition as it is related to a CCO member, refer to OAR 410-141-0000.

(3) "Acupuncturist" means a person licensed to practice acupuncture by the relevant state licensing board.

(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.

(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.

(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.

(7) "Addiction Division and Mental Health Division" means the Divisions within the Authority's Health Systems Division that administers mental health and addiction programs and services.

(8) "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.

(9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records, requested on the OHP 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.

(10) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.

(11) "Adverse Event" means an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

(12) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."

(13) "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.

(14) "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 individuals (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).

(15) "Alternative Care Settings" means 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.

(16) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured persons that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.

(17) "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).

(18) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.

(19) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and 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.

(20) "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).

(21) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.

(22) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.

(23) "Appeal" means a request for review of an action.

(24) "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.

(25) "Atypical Provider" means an entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

(26) "Audiologist" means a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(27) "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.

(28) "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.

(29) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

(30) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.

(31) "Behavioral Health Case Management" means services provide to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.

(32) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.

(33) "Benefit Package" means the package of covered health care services for which the client is eligible.

(34) "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.

(35) "Billing Provider (BP)" means a person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to 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.

(36) "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.)

(37) "By Report (BR)": means services designated, as BR requires 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.

(38) "Case Management Services" means 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 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 that may include referrals to Allied Agencies.

(39) "Certified Traditional Health Worker" means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.

(40) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.

(41) "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.

(42) "Chiropractor" means a person licensed to practice chiropractic by the relevant state licensing board.

(43) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.

(44) "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).

(45) "Claimant" means a person who has requested a hearing.

(46) "Client" means an individual found eligible to receive OHP health services.

(47) "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.

(48) "Clinical Social Worker" means a person licensed to practice clinical social work pursuant to state law.

(49) "Clinical Record" means the medical, dental, or mental health records of a client or member.

(50) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.

(51) "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.

(52) "Community Health Worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;

(f) Provides health education and information that is culturally appropriate to the individuals being served;

(g) Assists community residents in receiving the care they need;

(h) May give peer counseling and guidance on health behaviors; and

(i) May provide direct services such as first aid or blood pressure screening.

(53) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority's Addictions and Mental Health Division (AMH).

(54) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV); and treatments described in the Current Procedural Terminology, 4th edition (CPT-4); or American Dental Association Codes (CDT-2) or the Authority AMH Medicaid Procedure Codes and Reimbursement Rates, that, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.

(55) "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.

(56) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.

(57) "Contiguous Area Provider" means a provider practicing in a contiguous area.

(58) "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.

(59) "Coordinated Care Organization (CCO)" as defined in OAR 410-141-0000.

(60) "Co-Payments" means 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.)

(61) "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.

(62) "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.

(63) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(64) "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.

(65) "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.

(66) "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.

(67) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.

(68) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(69) "Dental Services" means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.

(70) "Dentist" means a person licensed to practice dentistry pursuant to state law of the state in which he or 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.

(71) "Denturist" means a person licensed to practice denture technology pursuant to state law.

(72) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.

(73) "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.

(74) "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.

(75) "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.

(76) "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.

(77) "Department Representative" means a person who represents the Department and presents the position of the Department in a hearing.

(78) "Diagnosis Code" means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(79) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.

(80) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(81) "Division (Division)" means the Health Systems 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.

(82) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means 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.

(83) "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.

(84) "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.

(85) "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.

(86) "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.

(87) "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.

(88) "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)).

(89) "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.

(90) "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.

(91) "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)).

(92) "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.

(93) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.

(94) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that 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.

(95) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating 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.

(96) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(97) "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.

(98) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.

(99) "Health Care Interpreter" Certified or Qualified as defined in ORS 413.550.

(100) "Health Care Professionals" means 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.

(101) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level l — 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, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(102) "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.

(103) "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.

(104) "Health Maintenance Organization (HMO)" means a public or private health care organization that 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.

(105) "Health Plan New/non-categorical 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.

(106) "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.

(107) "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.

(108) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that 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.

(109) "Home Health Services" means 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.

(110) "Home Intravenous Services" means 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.

(111) "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.

(112) "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 is currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(113) "Hospital" means a facility licensed by the Office of Public Health Systems as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as 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.

(114) "Hospital-Based Professional Services" means 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.

(115) "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 or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(116) "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.

(117) "Indian Health Care Provider" means an Indian health program or an urban Indian organization.

(118) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.

(119) "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.

(120) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in 813.602(5).

(121) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(122) "Inpatient Hospital Services" means 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.)

(123) "Institutional Level of Income Standards (ILIS)" means 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 Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.

(124) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.

(125) "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(126) "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 and 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).

(127) "Laboratory Services" means 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 or 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.

(128) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.

(129) "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.

(130) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.(131) "Managed Care Organization (MCO)" means a 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), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(132) "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 that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.

(133) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.

(134) "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.

(135) "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.

(136) "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).

(137) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.

(138) "Medical Transportation" means transportation to or from covered medical services.

(139) "Medically Appropriate" means services and medical supplies that are 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, 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 that can be safely provided to a Division client or CCO member in the Division or CCO's judgment.

(140) "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 that 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. It 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.

(141) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(142) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is 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.

(143) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(144) "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.

(145) "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.

(146) "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.

(147) "Naturopathic physician" means a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

(148) "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.

(149) "Non-covered Services" means 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.

(150) "Non-Emergent Medical Transportation Services (NEMT)"means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000(76) and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

(151) "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).

(152) "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.

(153) "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.

(154) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.

(155) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.

(156) "Nursing Services" means 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.

(157) "Nutritional Counseling" means counseling that takes place as part of the treatment of a person with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(158) "Occupational Therapist" means a person licensed by the State Board of Examiners for Occupational Therapy.

(159) "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, the 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.

(160) "Ombudsman Services" means 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.

(161) "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.

(162) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that 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

(163) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.

(164) "Optometrist" means a person licensed to practice optometry pursuant to state law.

(165) "Oregon Health Authority (Authority)" 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 Oregon Health Authority are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs.

(166) "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.

(167) "Out-of-State Providers" means 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.

(168) "Outpatient Hospital Services" means 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.

(169) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.

(170) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(171) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.

(172) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.

(173) "Panel" means the Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(174) "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.

(175) "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.

(176) "Peer Wellness Specialist" means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.

(177) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and will assist the patient in achieving the goals.

(178) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions, and desired outcome.

(179) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his or her scope of practice.

(180) "Pharmacist" means a person licensed to practice pharmacy pursuant to state law.

(181) "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.

(182) "Physical Therapist" means a person licensed by the relevant state licensing authority to practice physical therapy.

(183) "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 may not include radiology or electrosurgery.

(184) "Physician" means a person licensed to practice medicine pursuant to state law of the state in which he or 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 ORS 685.

(185) "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.

(186) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.

(187) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.

(188) "Podiatrist" means a person licensed to practice podiatric medicine pursuant to state law.

(189) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.

(190) "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 or certification.

(191) "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), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(192) "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.

(193) "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.

(194) "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.

(195) "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.

(196) "Private Duty Nursing Services" means 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.

(197) "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 unless otherwise specified.

(198) "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) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)

(199) "Public Health Clinic" means a clinic operated by a county government.

(200) "Public Rates" means 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.

(201) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.

(202) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.

(203) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.

(204) "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.

(205) "Radiological Services" means 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.

(206) "Recipient" means a person who is currently eligible for medical assistance (also known as a client).

(207) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(208) "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.

(209) "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.

(210) "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.

(211) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.

(212) "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.

(213) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

(214) "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.

(215) "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.

(216) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.

(217) "Sanction" means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.

(218) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

(219) "Self-Sufficiency" means the division in the Department of Human Services (Department) that administers programs for adults and families.

(220) "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.

(221) "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.

(222) "Social Worker" means a person licensed by the Board of Clinical Social Workers to practice clinical social work.

(223) "Speech-Language Pathologist" means a person licensed by the Oregon Board of Examiners for Speech Pathology.

(224) "Speech-Language Pathology Services" means 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.

(225) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.

(226) "Subparts (of a Provider Organization)" means 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 and could be components of an organization or separate physical locations of an organization.

(227) "Subrogation" means right of the state to stand in place of the client in the collection of third party resources (TPR).

(228) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the American Society of Addiction Medicine Patient Placement Criteria 2-Revision (ASAM PPC-2R). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

(229) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.

(230) "Surgical Assistant" means a person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(231) "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.

(232) "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.

(233) "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.

(234) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.

(235) "Transportation" means medical transportation.

(236) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.

(237) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.

(238) "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.

(239) "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.

(240) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.

(241) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.

(242) "Urgent Care Services" means 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.

(243) "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 percent 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.

(244) "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.

(245) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:

(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).

(246) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:

(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and

(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.

(247) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

(248) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department 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; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 57-2014, f. 9-26-14, cert. ef. 10-1-14; DMAP 5-2015, f. & cert. ef. 2-10-15; DMAP 29-2015, f. & cert. ef. 5-29-15; DMAP 55-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 30-2016, f. 6-29-16, cert. ef. 7-1-16; DMAP 31-2016, f. 6-29-16, cert. ef. 7-1-16

410-125-0080

Inpatient Services

(1) Elective (not urgent or emergent) hospital admission:

(a) Coordinated Care Organization (CCO) and Mental Health Organization (MHO) clients: Contact the client's CCO, or MHO. The health plan may have different prior authorization (PA) requirements than the Division;

(b) Medicare clients: The Division does not require PA for inpatient services provided to clients with Medicare Part A or B coverage;

(c) Division clients: Oregon Health Plan (OHP) clients covered by the OHP Plus Benefit Package:

(A) For a list of medical and surgical procedures that require PA, see the Division's Medical-Surgical Services Program, rules OAR chapter 410, division 130, specifically OAR 410-130-0200, table 130-0200-1, unless they are urgent or emergent defined in OAR 410-125-0401;

(B) For PA, contact the Division unless otherwise indicated in the Medical-Surgical Service program rules, specifically OAR 410-130-0200, Table 130-0200-1.

(2) Transplant services:

(a) Complete rules for transplant services are in the Division's Transplant Services Program rules, OAR chapter 410, division 124;

(b) Clients are eligible for transplants covered by the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List). See the Transplant Services Program administrative rules for criteria. (3) Out-of-State non-contiguous hospitals:

(a) All non-emergent and non-urgent services provided by hospitals more than 75 miles from the Oregon border require PA;

(b) Contact the Division's Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP, contact the plan.

(4) Out-of-State contiguous hospitals: The Division prior authorizes services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, following the same rules and procedures governing in-state providers.

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in the Medical-Surgical Services program rules, specifically OAR 410-130-0200, Table 130-0200-1, e.g., inpatient physical rehabilitation care, require PA. (b) For transfers to a skilled nursing facility, intermediate care facility, or swing bed, contact Aging and People with Disabilities (APD). APD reimburses nursing facilities and swing beds through contracts with the facilities. For CCO clients, transfers require authorization and payment (for first 20 days) from the CCO;

(c) For transfers for the same or lesser level inpatient care to a general acute-care hospital, the Division shall cover transfers, including back transfers that are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social or psychological benefit to the patient:

(A) The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support;

(B) Payment for transfers not meeting these guidelines may be denied on the basis of post-payment review.

(d) Exceptions:

(A) Emergency transfers do not require PA;

(B) In-state or contiguous non-emergency transfers for the purpose of providing care that is unavailable in the transferring hospital do not require PA unless the planned service is listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1;

(C) All non-urgent transfers to out-of-state, non-contiguous hospitals require PA.

(6) Dental procedures provided in a hospital setting:

(a) For prior authorization requirements, see the Division's Dental Services Program rules; specifically OAR 410-123-1260 and 410-123-1490;

(b) Emergency dental services do not require PA;

(c) For prior authorization for fee-for-service clients, contact the Division's Dental Services Program analyst. (See the Division's Dental Services Program Supplemental information, http://www.oregon.gov/OHA/healthplan/pages/dental.aspx);

(d) For clients enrolled in a CCO, contact the client's health plan.

(7) Long-term acute care (LTAC) hospital services authorization requirements:

(a) For an initial thirty-day stay:

(A) LTAC provider must, before admitting the client, submit a request for prior authorization to the Division;

(B) Include sufficient medical information to justify the requested initial stay;

(C) Meet the clinical criteria outlined in the LTAC Hospital guide at: http:www.oregon.gov/oha/healthplan/Pages/hospital.aspx.

(b) Extension of stay:

(A) Submit request for prior authorization to the Division;

(B) Include sufficient medical justification for the extended stay.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & 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 11-1983, f. 3-8-83, ef. 4-1-83; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 36-1984, f. & ef. 8-20-84; AFS 22-1985, f. 4-23-85, ef. 6-1-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 45-1989, f. & cert. ef. 8-21-89; HR 9-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0190; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 7-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 9-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 27-2007(Temp), f. & cert. ef. 12-20-07 thru 5-15-08; DMAP 12-2008, f. 4-29-08, cert. ef. 5-1-08; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 17-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 32-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 37-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 23-2014, f. & cert. ef. 4-4-14; DMAP 31-2016, f. 6-29-16, cert. ef. 7-1-16

410-125-0141

DRG Rate Methodology

(1) Diagnosis Related Groups:

(a) Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM);

(b) The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) Medicare Grouper: The Medicare Grouper is the software used to assign an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Division uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, the Division may modify the logic of the grouper program. The Division will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. The Division DRG weight tables can be found on the Division web site:

(a) Acute Care Hospitals larger than fifty beds are considered DRG hospitals and reimbursed using Medicare's MS-DRG grouper;

(b) Hospitals enrolled as long-term acute care (LTAC) are reimbursed using Medicare's MS-LTC DRG grouper.

(3) DRG Relative Weights:

(a) Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category;

(b) For most DRGs, the Division establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, the Division uses the following methodology: Using the formula N = where Z = 1.15 (a 75 percent confidence level), S is the standard deviation, and R = 10 percent of the mean. The Division determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, the Division sets a relative weight using:

(A) Division non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the Division Title XIX caseload;

(c) When a test shows at the 90 percent confidence level that an externally derived weight is not representative of the average cost of services provided to the Division Title XIX population in that DRG, the weight derived from the Division Title XIX claims history is used instead of the externally derived weight for that DRG;

(d) Those relative weights based on Federal Medicare DRG weights will be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by the Division. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Reweighing of DRGs or the addition or modification of the grouper logic will not result in a reduction of overall payments or total relative weights.

(4) Case Mix Index: The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) Unit Value: Hospitals larger than fifty beds or enrolled as a long-term acute care (LTAC) hospital are reimbursed using the Diagnosis Related Grouper (DRG) as described in section (2). Effective for services on or after:

(a) August 15, 2005, the operating unit payment is 100 percent of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(b) May 1, 2009, the operating unit payment is 108.5 percent of the 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge;

(c) Effective October 1, 2009 the operating unit payment is 100 percent of the most recent version of the Medicare base payment rates. The Division will revise the base payment rates each year in October when Medicare posts the rates.

(6) DRG Payment: The DRG payment to each Oregon DRG hospital or LTAC hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out-of-state hospitals do not receive the capital amount).

(7) DRG Hospital Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients;

(b) For dates of service on and after March 1, 2004, the calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:

(A) Non-covered services (such as ambulance charges) are deducted from billed charges;

(B) The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;

(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made;

(D) Costs which exceed the threshold ($25,000 or 270 percent of the DRG payment, whichever is greater) are reimbursed using the following formula:

(i) Billed charges less non-covered charges, multiplied by;

(ii) Hospital-specific cost-to-charge ratio equals;

(iii) Net Costs, minus;

(iv) 270 percent of the DRG or $25,000 (whichever is greater), equals;

(v) Outlier Costs, multiplied by;

(vi) Cost Outlier Percentage, (cost outlier percentage is 50 percent), equals;

(vii) Cost Outlier Payment;

(E) Third party reimbursements are deducted from the Division calculation of the payable amount;

(F) When hospital cost reports are audited during the cost settlement process, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and cost statement template, adjusted to reflect the Medicaid mix of services.

(8) LTAC Short Stay Outliers: Occurs when a covered length of stay is between one day and up to and including 5/6ths of the average length of stay for the LTC-DRG grouping. The Short Stay Outlier payment for the hospital will be the lesser of:

(a) Per Diem for Short Stay Outlier Calculation:

(A) MS-LTC DRG payment, divided by;

(B) Geometric Length of Stay (GLOS,) multiplied by;

(C) Actual length of stay, multiplied by;

(D) 120 percent equals;

(E) Per Diem payment;

(b) Full MS-LTC DRG payment.

(9) LTAC High Cost Outliers: Are an additional payment when the estimated cost of a claim exceeds the outlier threshold (LTC DRG payment plus a fixed loss amount):

(a) The fixed loss amount is published annually by Medicare;

(b) If the estimated cost of a claim is greater than the outlier threshold, an additional payment is added to the LTC DRG payment;

(c) The outlier payment is 80 percent of the difference between the estimated cost of the claim and the outlier threshold (LTC DRG payment plus the fixed loss amount);

(d) The estimated cost of the claim is calculated by multiplying the Division's allowable charge on the claim by the hospital's cost-to-charge ratio.

(10) Capital:

(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Division uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004, the Capital cost per discharge is 100 percent of the published Medicare capital rate for fiscal year 2004, see section (5). The capital cost is added to the Unit Value and paid per discharge;

(c) Effective October 1, 2009, the Capital cost per discharge is one 100 percent of the current year Medicare capital rate and updated every October thereafter, see section (5). The capital cost is added to the Unit Value and paid per discharge.

(11) Direct Medical Education:

(a) The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Division uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Direct medical education cost per discharge is calculated as follows:

(A) The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986, through June 30, 1987, are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX direct medical education cost per discharge;

(B) The Title XIX direct medical education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment;

(c) Direct medical education payment per discharge:

(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85 percent. Payment is made within thirty days of the end of the quarter;

(B) The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity, and other relevant factors.

(C) Notwithstanding section (9) of this rule, this subsection becomes effective for dates of service:

(i) On July 1, 2006, and thereafter direct medical education payments will not be made to hospitals; and

(ii) On July 1, 2008, and thereafter direct medical education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

(12) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to in-state hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients;

(b) Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs;

(c) Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the state's fiscal year is the Division indirect medical education factor. This factor is used for the entire Oregon Fiscal Year;

(d) For dates of service on and after March 1, 2004, the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital-specific February 29, 2004, Unit Value, multiplied by the Indirect Factor, equals the Indirect Medical Education Payment;

(e) Effective October 1, 2009, the calculation of the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital unit value, see (5)(c), multiplied by the indirect factor, equals the Indirect Medical Education Payment;

(f) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter;

(g) Notwithstanding section (10) of this rule, this subsection becomes effective for dates of service:

(A) On July 1, 2006, and thereafter Indirect Medical Education payment will not be made to hospitals; and

(B) On July 1, 2008, and thereafter Indirect Medical Education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570, 461-015-0590, 461-015-0600 & 461-015-0610; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 42-1990, f. & cert. ef. 11-30-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840, 410-125-0880, 410-125-0900, 410-125-0920, 410-125-0960 & 410-125-0980; HR 35-1993(Temp), f. & cert. ef. 12-1-93; HR 23-1994, f. 5-31-94, cert. ef. 6-1-94; HR 11-1996(Temp), f. & cert. ef. 7-1-96; HR 22-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 45-1998, f. & cert. ef. 12-1-98; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 16-2003(Temp), f. & cert. ef. 3-10-03 thru 8-1-03; OMAP 37-2003, f. & cert. ef. 5-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 78-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; Administrative correction, 3-18-05; OMAP 21-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 37-2005(Temp) f. & cert. ef. 8-15-05 thru 1-15-06; OMAP 70-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 10-2009(Temp), f. 4-29-09, cert. ef. 5-1-09 thru 10-28-09; DMAP 31-2009, f. 9-22-09, cert. ef. 10-1-09; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 31-2016, f. 6-29-16, cert. ef. 7-1-16

410-125-0400

Discharge

(1) A discharge from a hospital is the formal release of a patient to home, to another facility such as an intermediate care facility or nursing home, to a home health care agency, or to another provider of health care services.

(2) For services beginning January 1, 1993, and later, the transfer of a patient from acute care to a distinct part physical rehabilitation unit (i.e., a unit exempt from the Medicare Prospective Payment System) within the same hospital will be considered a discharge. The admission to the rehabilitation unit is billed separately. All other transfers occurring within a hospital, including transfers to Medicare PPS-exempt psychiatric units, will not be considered discharges, and all charges for services must be submitted on a single UB-04 billing for the admission.

(3) Transfer from a hospital occurs when an individual is formally released to another acute care hospital, to a long-term acute care hospital, to a skilled nursing facility, or an intermediate care facility. When a physician sends a patient directly to another hospital for further inpatient care,

the discharge should be billed as a transfer, regardless of the mode of transportation.

(4) When the Division receives claims from two hospitals for the same patient, and the date of discharge from one hospital is the same as the date of admission to the other, the Division will assume that a transfer has occurred. The Division will change the discharge status code on the first claim to 02 (Transferred to Another Acute Care Facility), automatically generating an adjustment if the claim has already been adjudicated, unless discharge status on the claim is already 02 (Transfer) or 07 (Discharge AMA). If it is believed that the Division made an error in assigning Discharge Status code 02 to a claim, the hospital may submit an Adjustment Request along with supporting documentation from the medical record.

(5) A transfer between units within a hospital is not a transfer for billing purposes, except in the case of transfers to distinct part physical rehabilitation units. Note that transfers in the other direction from rehabilitative care to acute care are not considered discharges from the rehabilitation unit unless the stay in the acute setting exceeds seven days. Stays of seven days or less in the acute care setting may not be billed separately.

(6) Some transfers, including transfers to distinct part rehabilitation units, require prior authorization.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 31-2016, f. 6-29-16, cert. ef. 7-1-16

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Rule Caption: Align with Department of Human Services OAR Chapter 461 Rules
Adm. Order No.: DMAP 32-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-120-0006
Subject: In coordination with the Department of Human Services' (Department) revision of rules established in OAR chapter 461 for all overpayment, personal injury liens, and estate administration, the Division is amending OAR 410-120-0006 to assure that the Division's rule aligns with and reflects information found in the Department's amended rules. In OAR 410-120-0006, the Division adopts and incorporates Department rules and must update OAR 410-120-0006 accordingly. The Division is amending this rule that incorporates rules established in OAR Chapter 461 for all overpayment, personal injury liens, and estate administration for Authority programs covered under OAR 410-200. References to OAR Chapter 461 in contracts of the Authority are deemed to be references to the requirements of this rule.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

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 procedures consistent with applicable law. As outlined in OAR 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 for all overpayment, personal injury liens and estates administration for Authority programs covered under OAR chapter 410, division 200.

(2) Any reference to OAR chapter 461 in 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.

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. ef. 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; DMAP 39-2013(Temp), f. 7-26-13, cert. ef. 8-1-13 thru 1-28-14; DMAP 44-2013(Temp), f. 8-21-13, cert. ef. 8-23-13 thru 1-28-14; DMAP 51-2013, f. & cert. ef. 10-1-13; DMAP 52-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 55-2013(Temp), f. & cert. ef. 10-2-13 thru 3-31-14; DMAP 59-2013(Temp), f. 10-31-13, cert. ef. 11-1-13 thru 3-31-14; DMAP 9-2014(Temp), f. 1-31-14, cert. ef. 2-1-14 thru 3-31-14; DMAP 18-2014, f. 3-28-14, cert. ef. 3-31-14; DMAP 41-2014, f. & cert. ef. 7-1-14; DMAP 54-2014, f. & cert. ef. 9-23-14; DMAP 12-2015(Temp), f. 3-5-15, cert. ef. 3-19-15 thru 9-14-15; DMAP 33-2015, f. 6-24-15, cert. ef. 7-1-15; DMAP 49-2015, f. 9-3-15, cert. ef. 10-1-15; DMAP 70-2015, f. 12-8-15, cert. ef. 1-1-16; DMAP 32-2016, f. 6-29-16, cert. ef. 7-1-16

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Rule Caption: Clarify Services, Billing, Qualifications for Providing IDEA Services to Children with Disabilities in Public Schools
Adm. Order No.: DMAP 33-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-133-0000, 410-133-0040, 410-133-0060, 410-133-0080, 410-133-0100, 410-133-0120, 410-133-0140, 410-133-0200, 410-133-0300, 410-133-0320
Subject: The Division needs to amend these rules to incorporate changes to the Board of Examiners for Speech-Language Pathology and Audiology pursuant to SB287 and in compliance with 42CFR 440.110. These rules are also being amended to correct OAR references, update, correct, and add definitions to clarify services, billing, and documentation in support of School-Based Health Services for assuring compliance with rules and regulations for audit purposes.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-133-0000
Purpose

(1) School-Based Health Services (SBHS) rules describe the Medicaid covered services available to Medicaid-eligible students receiving health services on a fee-for-service basis when "Necessary and Appropriate" and within the limitations established by the Medical Assistance Program and these rules, consistent with the requirements of the Individuals with Disabilities Education Act (IDEA). These rules are to be used in conjunction with the General Rules governing the Health Systems Division, Medical Assistance Programs (Division) (OAR 410 division 120) and the Oregon Health Plan (OHP) rules (OAR 410 division 141). The School-Based Health Services rules are also a user's manual designed to assist the Educational Agency (EA) in matching state and federal funds for Oregon's Medicaid-eligible students with disabilities.

(2) The Oregon Administrative Rules (OARs) in Chapter 581, division 15 for the Oregon Department of Education (ODE) outline Oregon's program to meet the federal provisions of the IDEA. These SBHS rules define Oregon's fee-for-service program to reimburse publicly funded education agencies for the health services provided under the IDEA to Oregon's Medicaid-eligible children.

(3) The Department of Human Services (Department), The Oregon Health Authority (Authority), and ODE recognize the unique intent of health services provided for Medicaid-eligible students with disabilities in the special education setting. The School-Based Health Services rules address the health aspects of special education services that are covered by Medicaid or the Children's Health Insurance Program (CHIP).

(4) The Authority endeavors to furnish School Medical (SM) providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements. The Authority does so by providing information on its website.

(5) Enrolled School-Based Health Services providers are responsible to maintain current publications provided by the Authority and the Division and to comply with the OARs in effect on the date of service the health service is provided.

(6) In order for the Authority to reimburse for health services provided in the school, the health services must be included as a covered service under the Oregon Health Plan (OHP). There is no benefit category in the

Medicaid statute titled "school health services" or "early intervention services." These rules do not create a new category of health benefits for this fee-for-service program.

(7) These rules describe health services that are covered services for Medicaid-eligible students, which are authorized and provided consistent with these rules.

(8) Medicaid-eligible students retain the ability to obtain services from any qualified Medicaid provider that undertakes to provide services to them. These rules do not require a Medicaid-eligible student to receive their health services solely from school medical providers.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0040
Definitions

In addition to the definitions in OAR 410-120-0000, the following definitions apply to these rules:

(1) "Adapted vehicle" means a vehicle specifically designed or modified to transport passengers with disabilities.

(2) "Adequate recordkeeping" means in addition to General Rules OAR 410-120-0000, Definitions and 410-120-1360, Requirements for Financial, Clinical, and Other Records, documentation in the student's educational record and on the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) showing the necessary and appropriate health services provided to the student detailed in the School-Based Health Services (SBHS) administrative rules (410-133-0000 and 410-133-0320).

(3) "Agent" means a third party or organization that contracts with a provider, allied agency, or Prepaid Health Plan (PHP) to perform designated services in order to facilitate a transaction or conduct other business functions on its behalf. Agents include billing agents, claims clearinghouses, vendors, billing services, service bureaus, and accounts receivable management firms. Agents may also be clinics, group practices, and facilities that submit billings on behalf of providers but the payment is made to a provider, including the following: an employer of a provider, if a provider is required as a condition of employment to turn over his fees to the employer; the facility in which the service is provided, if a provider has a contract under which the facility submits the claim; or a foundation, plan, or similar organization operating an organized health care delivery system, if a provider has a contract under which the organization submits the claim. Agents may also include electronic data transmission submitters.

(4) "Assessment" means a process of obtaining information to determine if a student qualifies for or continues to qualify for the Division covered school-based health services.

(5) "Assistive technology service" means services provided by medically qualified staff within the scope of practice under state law with training and expertise in the use of assistive technology (see 410-133-0080 Coverage and 410-133-0200 Not Covered Services in these rules).

(6) "Audiologist" means a licensed audiologist within the scope of practice as defined by state or federal law who meet the standards of licensing or certification for the health service provided as described in OAR 410-133-0120 Medically Qualified Staff.

(7) "Audiology" means assessment of children with hearing loss; determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders; provision of rehabilitative activities, such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving services.

(8) "Authority" means the Oregon Health Authority. (Please see General Rules 410-120-0000 Acronyms and Definitions.)

(9) "Billing agent or billing service" means a 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. Also see definition for Electronic Data Interchange (EDI) Submitter.

(10) "Billing Provider (BP)" means a person, agent, business, corporation, clinic, group, institution, or other entity that submits claims to and receives payment from the Division on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider. (See the Department-wide Support Services (DWSS) administrative rules in, chapter 407, division 120 Provider Rules, and the Division's General Rules OAR 410-120-1260 and SBHS OAR 410-133-0140.)

(11) "Billing time limit" means the period of time allowed to bill services to the Division See General Rules OAR 410-120-1300, Timely Submission of Claims. In general, those rules require initial submission within 12 months of the date of service or 18 months for resubmission.

(12) "Centers for Medicare and Medicaid Services (CMS)" means the federal regulatory agency for Medicaid programs.

(13) "Certification." See "licensure."

(14) "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 in Oregon by the Authority and the Division.

(15) "Clinical Social Work Associate (CSWA)" means a person working toward Licensed Clinical Social Worker (LCSW) licensure in compliance with Division 20, Procedure for Certification of Clinical Social Work Associates and Licensing of Licensed Clinical Social Workers, OAR Chapter 877 division 020.

(16) "Coordinated care" means services directly related to covered school-based health services (SBHS) specified in the individualized education program (IEP) or individualized family service plan (IFSP), performed by medically qualified staff, and allowed under OAR 410-133-0080 Coverage to manage integration of those health services in an education setting. Coordinated care includes the following activities:

(a) Conference. The portion of a conference in a scheduled meeting between medically qualified staff and interested parties to develop, review, or revise components of school-based health services provided to a Medicaid-eligible student to establish, re-establish, or terminate a Medicaid covered health service on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP); or to develop, review, or revise components of a health service currently provided to a Medicaid-eligible student to determine whether or not those covered health services continue to meet the student's needs as specified on the student's IEP or IFSP;

(b) Consultation. Performed by medically qualified staff within the scope of practice providing technical assistance to or conferring with special education providers, physicians, and families to assist them in providing a covered health service for Medicaid-eligible students related to a specific health service and health service goals and objectives in the individualized education program (IEP) or individualized family service plan (IFSP);

(c) Physician coordinated care. Meeting or communication with a physician in reference to oversight of care and treatment provided for a health service specified on a Medicaid-eligible student's individualized education program (IEP) or individualized family service plan (IFSP).

(17) "Cost Determination" means the process of establishing an annual discipline fee (cost rate), based on the prior-year actual audited costs, used by an EA for the purpose of billing for covered school-based health services (see 410-133-0245 Cost Determination and Payment in these rules).

(18) "Covered entity" means a health plan, health care clearing house, health care provider, or allied agency that transmits any health information in electronic form in connection with a transaction, including direct data entry (DDE), and that must comply with the National Provider Identifier (NPI) requirements of 45 CFR 162.402 through 162.414. When a school provides covered SBHS services in the normal course of business and bills Medicaid for reimbursed covered transactions electronically in connection with that health care such as electronic claims, it is then a covered entity and must comply with the HIPAA Administrative Simplification Rules for Transactions and Code sets and Identifiers with respect to its transactions.

(19) Data transmission means the transfer or exchange of data between the Department and a web portal or electronic data interchange (EDI) submitter by means of an information system that is compatible for that purpose and includes without limitation web portal, EDI, electronic remittance advice (ERA), or electronic media claims (EMC) transmissions.

(20) "Delegated Health Care Aide" means a non-licensed person trained and supervised by a licensed registered nurse (RN) or nurse practitioner (NP) to perform selected tasks of nursing care specific to the Medicaid-eligible student identified in the nursing plan of care pursuant to the Individualized Education Program/Individualized Family Service Plan (IEP/IFSP).

(21) "Delegation of nursing task" means a selected nursing task that is performed by an unlicensed person, trained and monitored by a licensed RN. Delegation and supervision of selected nursing tasks must comply with

Oregon Administrative Rules (OARs), Oregon State Board of Nursing, chapter 851, divisions 45 and 47. A school medical (SM) provider must maintain documentation of the actual delegation, training, supervision, and provision of the nursing service billed to Medicaid.

(22) "Department" means the Department of Human Services established in OAR chapter 407, including any divisions, programs, and offices as may be established therein.

(23) "Diagnosis code" means as identified in the International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM), the primary Diagnosis Code is shown in all billing claims, unless specifically excluded in individual Division provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280 Billing.

(24) "Direct services" means face-to-face delivery of health services by or under the direction of medically qualified staff who is the service provider to a Medicaid-eligible student.

(25) "Early Intervention/Early Childhood Special Education (EI/ECSE)": EI is a program designed to address the unique needs of a child age 0-3 years, and ECSE is a program for preschool children with a disability ages 3-5 years or eligible for Kindergarten.

(26) "Educational Agency (EA)" means for purposes of these rules, any public school, school district, Education Service District (ESD), state institution, or youth care center providing educational services to students, birth to age 21 through grade 12, that receives federal or state funds either directly or by contract or subcontract with the Oregon Department of Education (ODE).

(27) "Education records" means those records, files, documents and other materials that contain information directly related to a student and maintained by an Education Agency (EA) or by a person acting for such EA as set forth in OAR 581-021-0220. (A school-based health services (SBHS) provider is required to keep and maintain supporting documentation for Medicaid reimbursed school-based health services for a period of seven years; this documentation is part of the student's education record but may be filed and kept separately by school health professionals.) See 410-133-0320 Documentation and Recordkeeping Requirements in these rules.

(28) "Education Service District (ESD)" means an education agency established to offer a resource pool of cost-effective, education-related, physical or mental health-related, state-mandated services to multiple local school districts within a geographic area described in ORS 334.010.

(29) "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 Department designates for EDI transactions. For purposes of these rules (OAR 407-120-0100 through 407-120-0200), EDI does not include electronic transmission by web portal.

(30) "EDI submitter" means an individual or an entity authorized to establish an electronic media connection with the Department to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner. Also see definition for billing agent in these rules.

(31) "Electronic Verification System (EVS)" means eligibility information that have met the legal and technical specifications of the Division in order to offer eligibility information to enrolled providers.

(32) "Eligibility for special education services" means a determination by a designated education agency (EA) through a team that a child meets the eligibility criteria for early intervention (EI), early childhood special education (ECSE), or special education as defined in ORS 343 and OAR chapter 581, division 15.

(33) "Evaluation" —means procedures performed by medically qualified staff to determine whether a Medicaid-eligible student is disabled and the nature and extent of the health services the student needs under the Individuals with Disabilities Education Act (IDEA) and in accordance with Oregon Department of Education OAR chapter 581 division 15. The Authority can only reimburse evaluations that establish, re-establish, or terminate a school-based health services (SBHS) covered health service on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA).

(34) "Federal Medical Assistance Percentage (FMAP)" means the percentage of federal matching dollars for qualified state medical assistance program expenditures.

(35) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I -American Medical Association's Physician's Current Procedural Terminology (CPT), Level II – National codes, and Level III – Local codes. The Division uses HCPCS codes. See General Rules (OAR 410-120-1280 Billing).

(36) "Health assessment plan (nursing)" means a systematic collection of data for the purpose of assessing a Medicaid-eligible student's health or illness status and actual or potential health care needs in the educational setting. It includes taking a nursing history and an appraisal of the student's health status through interview information from the family and information from the student's past health or medical record. A SBHS provider is required to keep and maintain the health assessment plan and supporting documentation for Medicaid reimbursed health services described in a Medicaid-eligible student's individualized education program (IEP) or individualized family service plan (IFSP) for a period of seven years as part of the student's education record, which may be filed and kept separately by school health professionals. (See 410-133-0320 Documentation and Recordkeeping Requirements.)

(37) "Health care practitioner" means a person licensed pursuant to state law to engage in the provision of health care services within the scope of the health care practitioner's license and certification standards established by their health licensing agency. Medical provider and health care practitioner are interchangeable terms. See Definition for medical provider in these rules.

(38) "Health Evidence Review Commission (HERC)" means a 13-member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important and representing the comparable benefits of each service to the entire population to be served.

(39) "Health services" means medical evaluation services provided by a physician for diagnostic and evaluation purposes for a Medicaid-eligible student that is found eligible under the Individuals with Disabilities Education Act (IDEA) and leads to an established Individualized Education Program (IEP) or Individualized Family service Plan (IFSP), physical or mental health evaluations, and assessment or treatment performed by medically qualified staff to achieve the goals set forth in a Medicaid-eligible student's IEP or IFSP. A covered health service is one that is covered by the medical assistance program and is provided to enable the Medicaid-eligible student to benefit from a special education program (age 3-21) or to achieve developmental milestones in an early intervention program (age 0-3). "Health services" are synonymous with "medical services" in these rules. To determine whether a health service specified on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) is a covered School-Based Health Service (SBHS), see 410-133-0080 Coverage and 410-133-0200 Not Covered Services.

(40) "Health Systems Division, Medical Assistance Programs (Division)" means a division within the Oregon Health Authority (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.

(41) "ID number" means a number issued by the Authority used to identify Medicaid-eligible students. This number may also be referred to as recipient identification number, prime number, client medical ID Number, or medical assistance program ID number.

(42) "Individuals with Disabilities Education Act (IDEA)" means the federal law ensuring the rights of children with disabilities to a "free and appropriate education" (FAPE).

(43) "Individualized Education Plan (IEP)" means a written statement of an educational program for a child with a disability that is developed, reviewed, or revised in a meeting in accordance with Oregon Department of Education OAR chapter 581, division 15. When an IEP is used as a prescription for Medicaid reimbursement for covered School-Based Health Services (SBHS), it must include: type of health service, amount, and duration and frequency for the service provided. In order to bill Medicaid for covered health services, they must be delivered by or under the supervision of medically-qualified staff and must be recommended by a physician or appropriate health care practitioner acting within the scope of practice. See the definition of medically qualified staff in this rule.

(44) "Individualized Family Service Plan (IFSP)" means a written plan of early childhood special education (ECSE) services, early intervention (EI) services, and other services developed in accordance with criteria established by the Oregon Department of Education (ODE) for each child (ages birth to 5 years) eligible for IFSP services. The plan is developed to meet the needs of a child with disabilities in accordance with requirements and definitions in OAR chapter 581, division 15. When an IFSP is used as a prescription for Medicaid reimbursement for SBHS covered services, it must include: type of health service, amount, and duration and frequency for the service provided. In order to bill Medicaid for covered health serv-

ices, they must be delivered by or under the supervision of medically-qualified staff and must be recommended by a physician or health care practitioner within their scope of practice. See the definition of medically qualified staff in this rule.

(45) "Individualized Education Plan/Individualized Family Service Plan (IEP/IFSP) Team" means a group of teachers, specialists, and parents responsible for determining eligibility, and developing, reviewing, and revising an IEP or IFSP in compliance with the Oregon Department of Education (ODE) OAR chapter 581, division 15.

(46)" Licensed Clinical Social Worker (LCSW)" means a person licensed to practice clinical social work pursuant to state law.

(47) "Licensed Physical Therapist Assistant (LPTA)" means a person licensed to assist in the administration of physical therapy, solely under the supervision and direction of a physical therapist.

(48)" Licensed Practical Nurse (LPN)" means a person licensed to practice under the direction of a licensed professional within the scope of practice as defined by state law.

(49) "Licensure" means documentation from state agencies demonstrating that licensed or certified individuals are qualified to perform specific duties and a scope of services within a legal standard recognized by the licensing agency. In the context of health services, licensure refers to the standards applicable to health service providers by health licensing authorities. For health services provided in the State of Oregon, licensure refers to the standards established by the appropriate State of Oregon licensing agency.

(50) "Medicaid-eligible student" means the child or student who has been determined to be eligible for Medicaid health services by the Authority. For purposes of this rule, Medicaid-eligible student is synonymous with "recipient" or "Oregon Health Plan (OHP) client". For convenience, the term "student" used in these rules applies to both students covered by an Individualized Education Program (IEP) and children covered by an Individualized Family Service Plan (IFSP). Also for purposes of this rule, students or children whose eligibility is based on the Children's Health Insurance Program (CHIP) shall be referred to as Medicaid-eligible students.

(51) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians. Oregon's medical assistance program includes Medicaid services including the Oregon Health Plan (OHP) Medicaid Demonstration, and the Children's Health Insurance Program (CHIP). The Medical Assistance Program is administered by the Health Systems Division, Medical Assistance Programs (Division) of the Oregon Health Authority.

(52) "Medical Management Information System (MMIS)" means a data collection system for processing an integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" is identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to recipients, providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

(53) "Medical provider" means an individual licensed by the state to provide health services within their governing body's definitions and respective scope of practice. Medical provider and health care practitioner are interchangeable terms.

(54) "Medical services" means the care and treatment provided by a licensed health care practitioner to prevent, diagnose, treat, correct, or address a medical problem, whether physical, mental, or emotional. For the purposes of these rules, this term shall be synonymous with health services or health-related services listed on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), as defined in OAR chapter 581, division 15. Not all health-related services listed on an IEP or IFSP are covered as SBHS. See 410-133-0080 Coverage and 410-133-0200 Not Covered Services.

(55) "Medical transportation" means specialized transportation in a vehicle adapted to meet the needs of passengers with disabilities transported to and from a SBHS covered service.

(56) "Medically qualified staff" means:

(a) Staff employed by or through contract with an EA; and

(b) Licensed by the state to provide health services in compliance with state law defining and governing the scope of practice, described further in OAR 410-133-0120.

(57) "Medication management" means a task performed only by medically qualified staff within the scope of practice, pursuant to a student's Individualized Education Program/Individualized Family Service Plan (IEP/IFSP), which involves administering medications, observing for side effects, and monitoring signs and symptoms for medication administration.

(58) "National Provider Identifier (NPI)" means a federally directed provider number mandated for use on Health Insurance Portability Accountability Act (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.

(59) "Necessary and appropriate" health services means those health services described in a Medicaid-eligible student's IEP or IFSP 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 the Medicaid-eligible student or provider of the service; and

(d) The most cost-effective of the alternative levels of health services that can safely be provided to a Medicaid-eligible student.

(60) "Nursing Diagnosis and Management Plan" means a written plan that describes a Medicaid-eligible student's actual and anticipated health conditions that are amenable to resolution by nursing intervention.

(61) "Nursing Plan of Care" means written guidelines that are made a part of and attached to the Individualized Education Program (IEP) or individualized Family Service Plan (IFSP) that identify specific health conditions of the Medicaid-eligible student and the nursing regimen that is "necessary and appropriate" for the student. Development and maintenance of this plan includes establishing student and nursing goals and identifying nursing interventions (including location, frequency, duration, and delegation of care) to meet the medical care objective identified in their IEP or IFSP. See Oregon State Board of Nursing Practice Act, Division 47. The SBHS provider is responsible for developing the nursing plan of care and is required to keep and maintain a copy of the nursing plan of care as supporting documentation for Medicaid reimbursed health services. (See definition "Education records.")

(62) "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.

(63) "Nursing services" means services provided by a nurse practitioner (NP), registered professional nurse (RN), a licensed practical nurse (LPN), or delegated health care aide within the scope of practice as defined by state law. Nursing services include preparation and maintenance of the health assessment plan; nursing diagnosis and management plan; nursing plan of care, consultation, and coordination; and integration of health service activities, as well as direct patient care and supervision.

(64) "Observation" means surveillance or visual monitoring performed by medically-qualified staff as part of an evaluation, assessment, direct service, or care coordination for a necessary and appropriate Medicaid-covered health service specified on a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) to better understand the child's medical needs and progress in their natural environment. An observation by itself is not billable.

(65) "Occupational therapist (OT)" means a person licensed by the state's Occupational Therapy Licensing Board.

(66) "Occupational Therapist Assistant" means a person who is licensed as an occupational therapy assistant assisting in the practice of occupational therapy under the supervision of a licensed occupational therapist.

(67) "Occupational therapy" means assessing, improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation to improve the ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention initial or further impairment or loss of function. It also means obtaining and interpreting information, coordinating care, and integrating necessary and appropriate occupational therapy services relative to the Medicaid-eligible student.

(68) "Oregon Department of Education (ODE)" means the state agency that provides oversight to public educational agencies for ensuring compliance with federal and state laws relating to the provision of services required by the individuals with disabilities education act (IDEA).

(69) "Orientation and mobility training" means services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in school, home, and community. These services are not covered under School-Based Health Services (SBHS). (See OAR 410-133-0200 Not Covered Services.)

(70) "Performing provider" means a person, agent, business, corporation, clinic, group, institution, or other entity that is the provider of a service or item with the authority to delegate fiduciary responsibilities to a billing provider, also termed billing agent, to obligate or act on the behalf of the performing provider regarding claim submissions, receivables, and payments relative to the Medical Assistance Program. For the purposes of these SBHS rules, the school medical (SM) provider is the performing provider.

(71) "Physical Therapist" means a person licensed by the relevant state licensing authority to practice physical therapy. (See OAR chapter 848, division10 Licensed Physical Therapists and Licensed Physical Therapist Assistants; chapter 848 division 40 Minimum Standards for Physical Therapy Practice and Records.)

(72) "Physical Therapy" means assessing, preventing, or alleviating movement dysfunction and related functional problems, obtaining and interpreting information, and coordinating care and integrating necessary and appropriate physical therapy services relative to the student receiving treatments.

(73) "Prime Number" See definition of ID Number.

(74) "Prioritized List of Health Services" means the Oregon Health Evidence Review Commission's (HERC) prioritized list of health services with "expanded definitions' of ancillary services and preventative services and the HERC practice guidelines, as presented to the Oregon Legislative Assembly for the purpose of administering the Oregon Health Plan (OHP).

(75) "Procedure code." See definition of HCPC healthcare common procedure code.

(76) "Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health care services or items, also termed a performing provider, or bills, obligates, and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term "Provider" refers to both performing providers and billing providers unless otherwise specified. Payment can only be made to Division-enrolled providers who have by signature on the provider enrollment forms and attachments agreed to provide services and to bill in accordance with General Rules OAR 410-120-1260 and the SBHS OAR 410-133-0140. If a provider submits claims electronically, the provider must become a trading partner with the Authority and comply with the requirements of the Electronic Data Interchange (EDI) rules pursuant to OAR Chapter 407 division 120.

(77) "Provider enrollment agreement" means an agreement between the provider and the Authority that sets forth the conditions for being enrolled as a provider with the Authority and to receive a provider number in order to submit claims for reimbursement for covered SBHS provided to Medicaid-eligible students. Payment can only be made to Division-enrolled providers who have by signature on the provider enrollment forms and program applicable attachments agreed to provide services and to bill in accordance with Provider Rules chapter 407, division 120 and the Division's General Rules chapter 410, division 120, and these SBHS rules. Also see definitions for Trading Partner and Trading Partner Agreement in these rules.

(78) "Psychiatrist" means a person licensed to practice medicine and surgery in the State of Oregon and possesses a valid license from the Oregon Medical Board.

(79) "Psychologist" means a person with a doctoral degree in psychology and licensed by the State Board of Psychologist Examiners. See 858-010-0010.

(80) "Psychologist Associate" means a person who does not possess a doctoral degree that is licensed by the Board of Psychologists Examiners to perform certain functions within the practice of psychology under the supervision of a psychologist. See 858-010-0037 through 858-010-0038. An exception would be psychologist associate with the authority to function without immediate supervision. See OAR 858-010-0039.

(81) "Record keeping requirements" means An SBHS SM provider is required to keep and maintain the supporting documentation in compliance with the respective medical provider's scope of practice and governing licensure or certification board requirements for Medicaid reimbursed health services described in a Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) for a period of seven years as part of the student's education record, which may be filed and kept separately by school health professionals. (See OAR 410-133-0320.)

(82) "Re-evaluation" means procedures used to measure a Medicaid-eligible student's health status compared to an initial or previous evaluation are focused on evaluation of progress toward current goals, modifying goals or treatment, or making a professional judgment to determine whether or not the student will continue to receive continued care for a covered service pursuant to an IEP or IFSP under the Individuals with Disabilities Education Act (IDEA). Continuous assessment of the student's progress as a component of ongoing therapy services is not billable as a re-evaluation.

(83) "Regional program" means regional program services provided on a multi-county basis under contract from the Oregon Department of Education (ODE) to eligible children (birth to 21) visually impaired, hearing impaired, deaf-blind, autistic, and severely orthopedically impaired. A regional program may be reimbursed for covered health services it provides to Medicaid-eligible students through the school medical (SM) provider (e.g., public school district or ESD) that administers the program.

(84) "Registered Nurse (RN)" means a person licensed and certified by the Oregon Board of Nursing to practice as a registered nurse pursuant to state law.

(85) "Rehabilitative services" means for purposes of the School-Based Health Services (SBHS) program any health service that is covered by the Medical Assistance Program and that is a medical, psychological, or remedial health service recommended by a physician or other licensed health care practitioner within the scope of practice under state law and provided to a Medicaid-eligible student pursuant to an Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) under the Individuals with Disabilities Education Act (IDEA) that help the Medicaid eligible student keep, learn, or improve skills and functioning, including reduction, correction, stabilization, or functioning improvement of physical or mental disability of a Medicaid-eligible student. (See 410-133-0060.)

(86) "Related services" means for purposes of this rule related services as listed on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and may include: transportation and such developmental, corrective, and other supportive services (e.g., speech language, audiology services, psychological services, physical therapy, occupational therapy, social work services in schools, and nursing services) as are required to assist a child or student with a disability to benefit from special education, and includes early identification and assessment of disabling conditions in children.

NOTE: Not all "related services" are covered for payment by Medicaid. To determine whether a particular related service is a covered health service for a Medicaid-eligible student, see OAR 410-133-0080, Coverage and OAR 410-133-0200, Not Covered Services.

(87) "School-Based Health Services (SBHS)" means special education, related services, or early intervention services addressing health-related needs that help the Medicaid eligible student keep, learn, or improve skills and functioning and any services authorized under Oregon's approved Medicaid state plans that are also considered special education, related services, or early intervention that adversely affects the child/student's educational performance. SBHS services reimbursed by Medicaid are recommended by a physician or other licensed health care practitioner within the scope of practice under state law and provided to a Medicaid-eligible student pursuant to an Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) under the Individuals with Disabilities Education Act (IDEA) meeting the requirements of these rules and applicable federal and state laws and rules.

(88) "School medical (SM) provider" means an enrolled provider type established by the Division to designate the provider of school-based health services eligible to receive reimbursement from the Division. See the Authority's general rules chapter 943 division 120, the Division's General Rules OAR 410-120-1260, and School-Based Health Services Program OAR 410-133-0140 (School Medical (SM) Provider Enrollment Provisions).

(89) "Screening" means a limited examination to determine a Medicaid-eligible student's need for a diagnostic medical evaluation.

(90) "Special Education Services" means specially designed instruction to meet the unique needs of a child with a disability, including regular classroom instruction, instruction in physical education, home instruction, and instruction in hospitals, institutions, special schools, and other settings.

(91) "Speech-Language Pathology Assistant (SLPA)" means a person who is licensed by the Oregon State Board of Examiners for Speech-Language Pathology and Audiology and provides speech-language pathol-

ogy services under the direction and supervision of a speech-language pathologist licensed under ORS 681.250.

(92) "Speech-Language Pathologist" means a licensed speech pathologist within the scope of practice as defined by state or federal law licensed by the Oregon Board of Examiners for Speech-Language Pathology and Audiology or holds a license issued by the Teacher Standards and Practice Commission (TSPC) prior to July 1, 2016, exemption in ORS 681.230(4) pursuant to SB287, and holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA) or has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate. (See Medically Qualified Staff 410-133-0120.)

(93) "Speech-language pathology services" means assessment of children with speech-language disorders, diagnosis, and appraisal of specific speech-language disorders and referral for medical and other professional attention necessary for the rehabilitation of speech-language disorders and the provision of speech-language services for the prevention of communicative disorders. It includes obtaining and interpreting information, coordinating care, and integrating necessary and appropriate speech-language pathology services relative to the student receiving services.

(94) "State Education Agency (SEA)." See "Oregon Department of Education (ODE)."

(95)" State-operated school" means the Oregon School for the Deaf. See "Educational Agency."

(96) "Student health/medical/nursing records" means education records that document for purposes of the Health Systems Division, Medical Assistance Program the Medicaid-eligible student's diagnosis or the results of tests, screens, or treatments, treatment plan, the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), and the record of treatments or health services provided to the child or student in compliance with the respective licensed practitioner's scope of practice and licensure or certification.

(97) "Teacher Standards and Practices Commission (TSPC)" means the commission that governs licensing of teachers, personnel, service specialists, and administrators as set forth in OAR chapter 584. In order for schools or school providers to participate in the Medicaid program and receive Medicaid reimbursement, they must meet the Medicaid provider qualifications. It is not sufficient for a state to use Department of Education provider qualifications for reimbursement of Medicaid-covered health services provided in an education setting.

(98) "Testing Technician" means a person/technician adequately trained to administer and score specific tests as delegated under the direction and supervision of a licensee and maintains standards for the testing environment and testing administration as set forth in the American Psychological Association Standards for Educational and Psychological Tests (1999) and Ethical Principles for Psychologists (2002). See ORS 675.010(4) and 858-010-0002.

(99) "Trading partner" means a provider, prepaid health plan (PHP), clinic, or allied agency that has entered into a trading partner agreement with the Department in order to satisfy all or part of its obligations under a contract by means of electronic data interchange (EDI), electronic remittance advice (ERA), electronic media claims (EMC), or any other mutually agreed means of electronic exchange or transfer of data. EDI transactions must comply with the requirements of the EDI rules OAR 407-120-0100 through 407-120-0200. For the purposes of these rules EDI does not include electronic transmission by web portal.

(100) "Trading partner agreement (TPA)" means a specific request by a provider, PHP, clinic, or allied agency to conduct EDI transactions that governs the terms and conditions for EDI transactions in the performance of obligations under a contract. A provider, PHP, clinic, or allied agency that has executed a TPA will be referred to as a trading partner in relation to those functions.

(101) "Transportation Aide" means an individual trained for health and safety issues to accompany a Medicaid-eligible student transported to and from a covered Health Service as specified in the Individualized Education Program/individualized Family Service Plan (IEP/IFSP). The School Medical (SM) Provider must maintain documentation of the training, supervision, and provision of the services billed to Medicaid. For the purposes of these rules, individual transportation aides are included in the cost calculation for transportation costs and will not be billed separately. This computation will not include delegated health care aides for whom costs are direct costs.

(102) "Transportation as a related service" means specialized transportation adapted to serve the needs of a Medicaid-eligible student to and from a covered health service that is necessary and appropriate and described in the Individualized Education Program/individualized Family Service Plan (IEP/IFSP) as outlined in OAR 410-133-0080 (Coverage).

(103) "Transportation vehicle trip log" means a record or log kept specifically for tracking each transportation trip a Medicaid-eligible student receives transportation to or from a covered health service. (See SBHS OAR 410-133-0245, Cost Determination and Payment.)

(104) "Treatment Plan" means a written plan of care services, including treatment with proposed location, frequency and duration of treatment as required by the health care practitioner's health licensing agency.

(105) "Unit" means a service measurement of time for billing and reimbursement efficiency. One unit equals 15 minutes unless otherwise stated.

(106) "Visit" means a service measurement of time for billing and reimbursement efficiency. One visit equals the school provider's hourly cost rate for category of service provided (i.e., occupational therapy, physical therapy, speech therapy, etc.) specified in an IEP or IFSP, divided by 60 to yield a cost per minute, and multiplied by amount of service time provided in minutes. For billing purposes, a visit is always presented as one visit.

(107) "Web Portal submitter" means an individual or entity authorized to establish an electronic media connection with the Health Systems Division, Medical Assistance Programs to conduct a direct data entry transaction. A web portal submitter may be a provider or a provider's agent.

Stat. Auth.: ORS 413.042
Stats. Implemented: 413.042, 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 29-1993, f. & cert. ef. 10-1-93; HR 21-1995, f. & cert. ef. 12-1-95;OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0060
Health Services

(1) A School-based Health Service is a health service for a Medicaid-eligible student that meets the coverage requirements in OAR 410-133-0080 and that:

(a) Addresses physical or mental disabilities and health-related service needs and devices that help the child or student keep, learn, or improve skills and functioning that adversely affects the child or student's educational performance; and

(b) Is identified in a student's Individualized Education Program (IEP) or the Individualized Family Service Plan (IFSP); and

(c) Is recommended by a physician or other licensed health care practitioner within the scope of practice under state law.

(2) School-based health services that meet the requirements of section (1) of this rule may include:

(a) Physical Therapy Evaluations and Treatments that include assessing, preventing, or alleviating movement dysfunction and related functional problems, obtaining and interpreting information, and coordinating care and integrating services relative to the student receiving treatments such as:

(A) Neuromotor or neurodevelopmental assessment;

(B) Assessing and treating problems related to musculo-skeletal status;

(C) Gait, balance, and coordination skills;

(D) Oral motor assessment;

(E) Adaptive equipment assessment;

(F) Gross and fine motor development;

(G) Observation of orthotic devices; and

(H) Prosthetic training.

(b) Occupational Therapy Evaluations and Treatments that include assessing, improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning when functions are lost or impaired; preventing through early intervention initial or further impairment or loss of function; obtaining and interpreting information; coordinating care; and integrating services relative to the student receiving services such as:

(A) Neuromuscular and musculo-skeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);

(B) Gross and fine motor development;

(C) Feeding or oral motor function;

(D) Adaptive equipment assessment;

(E) Prosthetic or orthotic training;

(F) Neuromotor or neurodevelopmental assessment;

(G) Gait, balance, and coordination skills.

(c) Speech Evaluation and Therapy Treatments that include assessment of children with speech and language disorders, diagnosis and appraisal of specific speech or language disorders, referral for medical and other professional attention necessary for the rehabilitation of speech-language disorders, provision of speech-language services for the prevention of communicative disorders, obtaining and interpreting information, coordinating care and integrating services relative to the student receiving services such as:

(A) Expressive language;

(B) Receptive language;

(C) Auditory processing, discrimination, perception and memory;

(D) Vocal quality;

(E) Resonance patterns;

(F) Phonological;

(G) Pragmatic language;

(H) Rhythm or fluency; and

(I) Feeding and swallowing assessment.

(d) Audiological Evaluation and Services that include assessment of children with hearing loss; determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders; provision of rehabilitative activities such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation; and determination of the child's need for individual amplification; obtaining and interpreting information; coordinating care and integrating services relative to the student receiving services such as:

(A) Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;

(B) Auditory discrimination in quiet and noise;

(C) Impedance audiometry, including tympanometry and acoustic reflex;

(D) Central auditory function;

(E) Testing to determine the child's need for individual amplification;

(F) Auditory training; and

(G) Training for the use of augmentative communication devices.

(e) Nurse Evaluation and Treatment Services that include assessments, treatment services, and supervision of delegated health care services provided to prevent disease, disability, other health conditions or their progression, prolong life, and promote physical and mental health and efficiency. This includes any medical or remedial services recommended by a physician or other licensed health care practitioner within the scope of practice under state law for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level. The RN is responsible for periodic supervision for services provided to coordinating care and integrating nursing tasks and services that can be performed in the educational setting such as:

(A) Monitoring patient's seizure activity for breathing patterns, onset/duration of seizure, triggers/auras, level of consciousness, support after seizure, administering medication as ordered;

(B) Monitoring and providing treatment for high and low blood sugar, checking urine keytones, blood glucose testing, carbohydrate calculations, assisting with insulin administration;

(C) Ventilator Care, suctioning, and equipment management;

(D) Tracheotomy care, changing dressings, emergency trach replacement, suctioning, changing "nose", and providing humidification as necessary;

(E) Catheterization, assisting with or performing procedure for catheterization, monitor urinary tract infections, and performing skin integrity checks;

(F) Gastrostomy tube feeding, administering tube feedings per physician order, monitoring skin status around the tube, and emergency treatment for button dislodgement;

(G) Medication pumps, e.g., insulin pump, calculate carbohydrate amounts in food/snacks, provide insulin bolus per physician order, emergency disconnect procedure and monitoring blood sugar; and

(H) Medication management, e.g., monitoring signs and symptoms for medication administration, administering medications, observing for side effects.

(f) Mental Health Evaluation and Treatment Services that include assessment and treatment services provided by or under the supervision and direction of a psychiatrist, psychologist, a mental health nurse practitioner, or by a social worker qualified and licensed to deliver the service and who may provide care coordination and integration for services relative to the student for outpatient mental health services received in the educational setting to prevent disease, disability, other health conditions or their progression, to prolong life and promote physical and mental health and efficiency. This includes any medical or remedial services recommended by a physician or other licensed health care practitioner within the scope of practice under state law for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level, such as:

(A) Mental health assessment;

(B) Psychological testing (non-educational cognitive and adaptive testing);

(C) Assessment of motor language, social, adaptive, and cognitive functioning by standardized developmental instruments;

(D) Behavioral health counseling and therapy; and

(E) Psychotherapy (group/individual).

(3) Services for physical, occupational, and speech therapy, hearing, nursing, and mental health services must be recommended as set out and provided by medically-qualified individuals as defined in OAR 410-133-0120.

(4) Medicaid covered services and treatments are considered as a covered service in accordance with Oregon's Medicaid program's Prioritized List of Health Services to recipients receiving services pursuant to an IEP/IFSP eligible under Individuals with Disabilities Education Act in the educational setting. The above-listed therapy services and treatments are examples of services that may be provided to eligible recipients in an educational setting under the Oregon Medicaid program. The current Prioritized List of services can be found on the Health Evidence Review Commission's (HERC) web site.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0080

Coverage

The Authority may reimburse school medical (SM) providers for covered health services that meet all of the following criteria:

(1) The health service must be "necessary and appropriate," considered as a covered service under the Oregon Health Plan (OHP) Prioritized List of health services, and the health service may not be excluded under OAR 410-133-0200 Not Covered Services.

(2) The health service must be required by a Medicaid-eligible student's physical or mental condition that adversely affects the child/student's educational performance and that helps the child/student keep, learn, or improve skills and functioning as specified on the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and further described in the treatment plan and the evaluation of the student.

(3) The health service, individual, or group may include corrective health services treatments and Medicaid-covered related services as described in a student's IEP or IFSP:

(a) The payment rate for health services includes case management and necessary supplies for these services. Additional reimbursement for such services are not paid separately from the health service;

(b) These services must be provided by medically-qualified staff that meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120 and comply with the respective medical provider's governing definitions, scope of practice, documentation requirements, and licensure or certification.

(4) Evaluation and assessment for SBHS are reimbursed for the part of the evaluation or assessment regarding a Medicaid-eligible student's "necessary and appropriate" SBHS needs for the purpose of establishing, re-establishing, or terminating a Medicaid-covered service on a Medicaid-eligible student's IEP or IFSP or to develop, review, or revise components of a covered health service currently provided to a Medicaid-eligible student for continuation of those covered services pursuant to an IEP or IFSP under the Individuals with Disabilities Education Act (IDEA):

(a) Evaluation services are procedures used to determine an SBHS covered health-related need, diagnosis, or eligibility under IDEA;

(b) Re-evaluation services are procedures used to measure a Medicaid-eligible student's health status compared to an initial or previous evaluation and is focused on evaluation of progress toward current goals, modifying goals or treatment, or making a professional judgment to determine whether or not a Medicaid-eligible student will continue to receive continued care for a SBHS covered service pursuant to the IEP or IFSP under IDEA. Continuous assessment of the student's progress as a component of ongoing therapy services is not billable as a re-evaluation.

(5) Assistive technology services directly assist a Medicaid-eligible student with a disability eligible under IDEA to receive assistive technology-covered SBHS as specified on the IEP or IFSP in the selection, acquisition, or use of an assistive technology device, including:

(a) The assistive technology assessment with one-to-one student contact time by medically-qualified staff within the scope of practice performing the assessment of the need, suitability, and benefits of the use of an assistive technology device or adaptive equipment that will help restore, augment, or compensate for existing functional ability in the Medicaid-eligible student or that will optimize functional tasks for the Medicaid-eligible student's environmental accessibility. This requires and includes the preparation of a written report;

(b) Care coordination with the Medicaid-eligible student's physician, parent/guardian, and the Division) for the parent/guardian's acquisition of a personal assistive technology device for their Medicaid-eligible student through the student's Medicaid plan for the benefit of the Medicaid-eligible student to maximize her functional ability and environmental accessibility; and

(c) Training or technical assistance provided to or demonstrated with the Medicaid-eligible student by medically-qualified staff, instructing the use of an assistive technology device or adaptive equipment in the educational setting with professionals (including individuals providing education and rehabilitation services) or where appropriate the family members, guardians, advocates, or authorized representative of the Medicaid-eligible student. In order to bill Medicaid for this service, the student must be present.

(6) The Authority may reimburse physical therapy services provided by:

(a) A physical therapist authorized to administer physical therapy to an individual when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, and is being seen pursuant to the Medicaid-eligible student's individual education plan or individual family service plan (see Oregon administrative rules chapter 848, division 10, Licensed Physical therapist and Licensed Physical Therapist Assistants; Division 15 Physical Therapist Assistants; and Division 40 Minimum Standards For Physical Therapy Practice and Records);

(b) A physical therapist assistant providing treatment under the supervision of a physical therapist that is available and readily accessible for consultation with the assistant at all times either in person or by means of telecommunications (see OAR chapter 848, division 15, Physical Therapist Assistants). Physical therapy services must be provided by medically-qualified staff that meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120;

(c) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report to establish necessary and appropriate physical therapy services on a Medicaid-eligible student's IEP or IFSP;

(B) Obtaining and interpreting medical information for the part of an evaluation or assessment performed by the physical therapist to establish necessary and appropriate physical therapy services on a Medicaid-eligible student's IEP or IFSP or to determine whether or not necessary and appropriate physical therapy services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA (cannot be delegated);

(C) Care coordination and integrating services within the scope of practice for providing necessary and appropriate physical therapy services relative to the Medicaid-eligible student pursuant to an IEP or IFSP;

(D) Direct treatment and supervision of services provided to a Medicaid-eligible student by the physical therapist and defined in the individual plan; when

(E) Documentation by the supervising physical therapist supporting the appropriate supervision of the assistant is maintained and kept by the School Medical Provider for a period of seven years (see OAR chapter 848, division 40, Minimum Standards for Physical Therapy Practice and Records);

(F) Individual or group physical therapy services provided to a Medicaid-eligible student by or under the supervision and direction of a licensed physical therapist pursuant to the Medicaid-eligible student's IEP or IFSP; when the documentation describing physical therapy services provided are signed by the therapist providing the service in accordance with their board licensing requirements, and documentation for supervision of services performed by or under the supervision and direction of the supervising physical therapist supporting the services provided is maintained and kept by the school medical provider for seven years (see Minimum Standards for Physical Therapy Practice and Records OARs 848-040-0100 through 848-040-0170);

(G) Other covered physical therapy services within the scope of practice and sections (1) and (2) of this rule.

(7) The Authority may reimburse occupational therapy services provided by:

(a) A licensed Occupational Therapist (OT) authorized to administer occupational therapy to an individual when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, and is being seen pursuant to the Medicaid-eligible student's individual education plan or individual family service plan; and

(b) A licensed occupational therapy assistant assisting in the practice of occupational therapy under the general supervision of a licensed occupational therapist. General supervision requires the supervisor to have at least monthly direct contact in person with the supervisee at the work site with supervision available as needed by other methods; and

(c) Before an occupational therapy assistant assists in the practice of occupational therapy, he must file with the Board a signed, current statement of supervision of the licensed occupational therapist that will supervise the occupational therapy assistant (see OAR 339-010-0035 Statement of Supervision for Occupational Therapy Assistant). Occupational therapy services must be provided by medically-qualified staff that meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120;

(d) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment reports that establish necessary and appropriate occupational therapy services on a Medicaid-eligible student's IEP or IFSP;

(B) Obtaining and interpreting medical information for the part of the evaluation or assessment performed by the occupational therapist to establish necessary and appropriate occupational therapy services on a Medicaid-eligible student's IEP or IFSP or to determine whether or not necessary and appropriate occupational therapy services will continue to be specified on the Medicaid eligible student's IEP or IFSP under IDEA (cannot be delegated);

(C) Development of the initial occupational therapy treatment plan by the OT (cannot be delegated);

(D) Coordinating care and integrating services within the scope of practice relative to the Medicaid-eligible student receiving necessary and appropriate occupational therapy services as specified on the IEP or IFSP;

(E) Individual or group occupational therapy services provided to a Medicaid-eligible student by or under the supervision and direction of a licensed occupational therapist as specified on Medicaid-eligible student's IEP or IFSP;

(F) Direct treatment and supervision of services provided to a Medicaid-eligible student by the occupational therapist and defined in the individual plan when documentation supporting the appropriate supervision of the assistant is kept and maintained by the school medical provider for a period of seven years;

(G) The occupational therapy services provided are consistent with OAR 339-010-0050 Occupational Therapy Services for Children and Youth in Education and Early Childhood Programs Regulated by Federal Laws; and

(H) Documentation describing occupational therapy treatment provided must be signed including credentials by the occupational therapist providing the service. Where appropriate, services provided by an occupational therapist assistant shall be reviewed and co-signed by the supervising occupational therapist. All documentation describing treatment provided by an occupational therapy assistant must name the assistant therapist and the supervising therapist including credentials as reflected on the current statement of supervision filed with the Occupational Therapist Licensing Board. Supervision and documentation of supervision by the supervising therapist for therapy provided by the occupational therapy assistant must meet general supervision requirements or closer supervision where professionally appropriate. See OAR 339-010-0005, 339-010-0035, and 339-010-0050. Also, see 410-133-0320 Documentation and Record Keeping Requirements in these rules;

(I) Other covered occupational therapy services within the scope of practice and sections (1) and (2) of this rule.

(8) The Authority may reimburse speech therapy services provided by:

(a) A licensed speech pathologist licensed by the Oregon Board of Examiners for Speech-Language Pathology and Audiology or holds a license issued by the Teacher Standards and Practice Commission (TSPC) prior to July 1, 2016, exemption in ORS 681.230(4) pursuant to SB287, and holds a Certificate of Clinical Competency (CCC) from the American Speech and Hearing Association (ASHA), or has completed the equivalent

educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate, or is authorized to administer speech therapy to an individual when the individual is a Medicaid-eligible student eligible for special education, as defined by state or federal law, receiving speech therapy services pursuant to an individual education plan or individual family service plan; or

(b) A graduate speech pathologist in their Clinical Fellowship Year (CFY) practicing under the supervision of al licensed speech pathologist with CCC meeting the standards of licensing or certification for the health service provided as described in OAR 410-133-0120 medically-qualified staff; and when:

(A) A standardized system for reviewing the clinical work of the clinical fellow is performed at regularly scheduled intervals, using the Skills Inventory Rating (CFSI) form addressing the fellow's attainment of skills for independent practice;

(B) The clinical fellow supervisor maintains and documents the supervision of the clinical fellow to be kept by the school medical provider for a period of seven years;

(C) Documentation describing the treatment provided is signed and initialed by the clinical fellow for review and co-signed by the supervising clinical fellow.

(c) Speech-language pathology assistants (SLPA), licensed by the Oregon State Board of Examiners for Speech-Language Pathology and Audiology, under the supervision of a supervising speech-language pathologist and who meet the standards of licensing or certification for the health service provided as described in OAR 410-133-0120 Medically Qualified Staff, when the following conditions are met:

(A) The supervising speech-language pathologist must have at least two years of full-time professional speech-language pathology experience (see OAR 335-095-0040 and 335-095-0050, Requirements for Supervising Licensed Speech-Language Pathology Assistants);

(B) The supervising speech therapist does not supervise more than the equivalent of two full-time speech-language pathology assistants;

(C) The supervising speech-language pathologist maintains documentation supporting the appropriate supervision of the assistant to be kept by the school medical provider for a period of seven years;

(D) The caseload of the supervising clinician allows for administration, including assistant supervision, evaluation of students and meeting times. All students assigned to an assistant are considered part of the caseload of the supervising clinician;

(E) The supervising speech-language pathologist must be able to be reached at all times. A temporary supervisor may be designated as necessary;

(F) The services provided by the assistants are consistent with the Scope of Duties for the Speech-Language Pathology Assistant (SLPA) pursuant to OAR 335-095-0060;

(G) Documentation describing the treatment provided is signed and initialed by the SLPA for review and co-signature by the supervising speech-language pathologist to be kept by the school medical provider for a period of seven years from date of payment.

(d) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report, including obtaining and interpreting medical information for the part of the evaluation or assessment performed by the speech pathologist to establish necessary and appropriate speech therapy services on a Medicaid-eligible student's IEP or IFSP or determine whether or not necessary and appropriate speech therapy services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA (cannot be delegated);

(B) Development of the initial speech therapy treatment plan by the speech pathologist (cannot be delegated);

(C) Care coordination and integrating services within the scope of practice relative to the Medicaid-eligible student receiving necessary and appropriate speech therapy services specified on the IEP or IFSP;

(D) Direct individual or group speech therapy services provided to a Medicaid-eligible student for speech services specified on the IEP or IFSP delivered by or under the supervision and direction of a speech pathologist who is medically qualified to deliver the service, see 410-133-0120 Medically Qualified Staff;

(E) Direct training and supervision of services provided to a Medicaid-eligible student by the medically qualified supervising speech pathologist to be kept by the school medical provider for a period of seven years; and

(F) Other covered speech therapy services within the scope of practice and sections (1) and (2) of this rule.

(9) The Authority may reimburse audiology services provided by:

(a) A licensed audiologist within the scope of practice as defined by state or federal law who meet the standards of licensing or certification for the health service provided as described in OAR 410-133-0120, Medically Qualified Staff;

(b) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report, including obtaining and interpreting medical information for the part of the evaluation or assessment performed by the audiologist within the scope of practice to establish necessary and appropriate hearing services on a Medicaid-eligible student's IEP or IFSP or determine whether or not necessary and appropriate hearing impairment services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA;

(B) Periodic hearing evaluations and assessments of a Medicaid-eligible student with hearing loss found eligible under IDEA pursuant to services as specified on the IEP or IFSP for determination of the range, nature, and degree of hearing loss;

(C) Care coordination and integration of services for medical or other professional attention relative to a Medicaid-eligible student receiving services for restoration or rehabilitation due to hearing and communication disorders as specified on the IEP or IFSP;

(D) Provision of rehabilitative activities such as language restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the Medicaid-eligible-student's need for individual amplification in accordance with the student's IEP or IFSP.

(10) The Authority may reimburse nurse services provided by:

(a) A nurse practitioner (NP), registered nurse (RN), licensed practical nurse (LPN), or delegated health care aid under the supervision of an RN or NP who meet the standards of licensing or certification for the health service provided as described in OAR 410-133-0120 Medically Qualified Staff;

(b) Nursing services under this program are not intended to reimburse nursing activities of a private duty RN or LPN that is otherwise billing Medicaid directly for those services;

(c) Reimbursement time may include:

(A) Preparation of the written initial evaluation or initial assessment report to establish nursing services including obtaining and interpreting medical information for the part of the evaluation or assessment performed to establish necessary and appropriate nursing services on the Medicaid-eligible student's IEP or IFSP or determine whether or not necessary and appropriate nursing services will continue to be specified on the Medicaid-eligible students IEP or IFSP under IDEA;

(B) Coordinated care for other specified care management for a chronic medical condition that is not addressed on the current IEP or IFSP that will result in amending nursing services specified in the IEP or IFSP and requires an updated nursing plan of care. This may result in an increase in supervision, monitoring, and training of DHC staff to provide new nursing tasks related to the change in condition, i.e., a child with seizure disorder that develops diabetes;

(C) Care coordination and integration of necessary and appropriate nursing services relative to the Medicaid–eligible student's covered health service specified on the IEP or IFSP;

(D) Nurse to student interactive services that are covered health services provided to a Medicaid-eligible student with a chronic medical condition receiving nursing services pursuant to an IEP or IFSP;

(E) Oversight of delegated health care aides performing delegated nursing services directly with the student as specified on the IEP or IFSP;

(F) Student observation by medically qualified staff for medical reasons of a Medicaid-eligible student with a chronic medical condition as part of an evaluation, assessment, or care coordination. An observation by itself is not a billable activity;

(G) Other covered nursing care services within the scope of practice and sections (1) and (2) of this rule.

(11) The Authority may reimburse mental health services provided by:

(a) A psychiatrist who meets the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(f)(A), or a psychologist who meets the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(f)(B), or a mental health nurse practitioner who meets the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(e)(A); or

(b) A psychologist associate with authority to function without immediate supervision, performing functions that may include but are not restricted to administering tests of mental abilities, conducting personality

assessments and counseling (see OAR 858-010-0039 Application for Independent Status). These services must be provided by medically-qualified staff who meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(f)(C); or

(c) A psychologist associate under the supervision of a psychologist as specified by the Board of Psychologist Examiners, OAR chapter 858, division 010. These services must be provided by medically-qualified staff who meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(2)(f)(D); or

(d) A technician under the supervision of a psychologist as specified by the Board of Psychologist Examiners, chapter 858, division 10, OAR 858-010-0002, Guidelines for Supervising Technicians, and who meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(f)(E); or

(e) An LCSW qualified and licensed to deliver the service, or a Clinical Social Work Associate (CSWA) under the supervision of an LCSW specified by the Board of Licensed Social Workers, chapter 877 division 20 and who meet the standards of licensing or certification for the health service being provided as described in OAR 410-133-0120(f)(F);

(f) Reimbursable time may include:

(A) Preparation of the written initial evaluation or initial assessment report for a suspected disability per the referral process for determining IDEA eligibility, including obtaining and interpreting medical information for the part of the evaluation or assessment performed by the mental health care practitioner within the scope of practice to establish necessary and appropriate mental health services on the Medicaid-eligible student's IEP or IFSP or to determine whether or not necessary and appropriate mental health services will continue to be specified on the Medicaid-eligible student's IEP or IFSP under IDEA;

(B) Care coordination and integrating services within the scope of practice relative to the Medicaid-eligible student receiving mental health services as specified on the IEP or IFSP;

(C) Direct individual therapy services provided within the scope of practice under state law and covered under sections (1) and (2) of this rule to a Medicaid-eligible student by or under the supervision and direction of a psychologist, a psychiatrist, or mental health nurse practitioner, or a Licensed Clinical Social Worker qualified and licensed to deliver the service pursuant to the Medicaid-eligible student's IEP or IFSP.

(12) Medicaid reimbursed transportation:

(a) Transportation to a covered health service as documented in the child's IEP/IFSP and defined in these rules (see 410-133-0245, Cost Determination and Payment);

(b) Ongoing transportation specified as a related service on the Medicaid-eligible student's IEP or IFSP may be claimed as a Medicaid service on the days a Medicaid-eligible student receives a covered health service that is also specified on the IEP or IFSP and the transportation is supported by a transportation vehicle trip log;

(c) The Authority may only reimburse for transportation as a related service to and from a Medicaid-covered service for a Medicaid-eligible student when the transportation is supported by a transportation vehicle trip log; and the student receives a Medicaid-covered health service other than transportation on that day when either of the following situations exist:

(A) The Medicaid-eligible student requires specialized transportation adapted to serve the needs of the disabled student; there is documentation to support specialized transportation is "necessary and appropriate;" and transportation is listed as a related service on the student's IEP or IFSP; or

(B) The Medicaid-eligible student has a medical need for transportation that is documented in the IEP or IFSP and resides in an area that does not have regular school bus transportation such as those areas in close proximity to a school.

(d) If a Medicaid-eligible student is able to ride on a regular school bus, but requires the assistance of a delegated health care aide trained by an RN to provide a delegated nursing task specific to the student and cannot be transported safely without the delegated health care aide, the service provided by the delegated healthcare aide is reimbursed under the delegated healthcare code. See the Standards for Community-Based Care Registered Nurse Delegation of a nursing care task as outlined in the Nurse Practice Act, OAR chapter 851 division 47;

(e) If a Medicaid-eligible student requires the assistance of a delegated health care aide and transportation adapted to serve the needs of the disabled student, both the necessary and appropriate transportation and the service provided by the delegated healthcare aide may be reimbursed when both are specified on the Medicaid-eligible student's current IEP or IFSP;

(f) If an education agency provides special transportation to a Medicaid-eligible student to a covered service outside the district or the Medicaid-eligible student's resident school and the student cannot be transported safely without a transportation aide as specified on the IEP or IFSP, the transportation is billable. However, a transportation aide who is not a delegated healthcare aide trained by an RN cannot be billed as a separate cost because the cost of the transportation aide is included in the cost of the transportation;

(g) Transportation is not reimbursable by the Division when provided by the parent or relative of the child;

(h) Transportation to an "evaluation" service is covered as long as:

(A) Medically necessary transportation is listed and included in the Medicaid-eligible student's current IEP or IFSP and the evaluation is to establish, re-establish, or terminate a SBHS covered service under IDEA;

(B) The evaluation is a SBHS covered health service;

(C) The medical provider conducting the evaluation, if not employed or contracted by the school medical provider, is an enrolled provider with the Division and meets applicable medical licensing standards necessary to conduct the evaluation.

(13) Medicaid may reimburse for contracted consultation health services for furnishing consultations regarding a Medicaid-eligible student's covered health service specified on the IEP or IFSP for an evaluation or assessment to establish, re-establish, or terminate a covered SBHS on an IEP or IFSP. Contracted consultation services must be provided by a licensed medical professional other than school medical provider staff:

(a) This service may be on a contracted basis for a number of students;

(b) Allowable services must be furnished through a personal service contract between the school medical provider and the licensed health care practitioner;

(c) This service would only be an SBHS covered health service by the school medical provider when the licensed health care practitioner did not bill Medicaid directly under other programs for the same services.

(14) Reimbursed coordinated care performed by medically qualified staff as described in OAR 410-133-0120 directly related to health services required by a Medicaid-eligible student's physical or mental condition as described in the IEP or IFSP must be one of the following:

(a) Managing integration of those Medicaid covered health services for treatment provided in the education setting;

(b) The portion of a conference between interested parties and medically-qualified staff for developing, reviewing, or revising a Medicaid-covered health service or therapy treatment plan for services provided pursuant to a Medicaid-eligible student's IEP or IFSP or to establish, re-establish, or terminate a covered health service under IDEA for eligibility purposes;

(c) Consultation from medically qualified staff providing technical assistance to or conferring with special education providers, physicians, or families to assist them in providing covered health services to Medicaid-eligible students for treatment provided in the educational setting related to specific health services and the goals and objectives in the student's IEP or IFSP. Consultation services must be completed by a licensed health care practitioner within the scope of practice under their licensure.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042, 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 31-2003, f. & cert ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0100

School Medical Provider Requirements

The School Medical (SM) provider is responsible to:

(1) Enroll with the Authority's Division, Medical Assistance Programs to provide health services and comply with all the requirements in the Authority's provider rules OAR chapter 943 division 120, General Rules OAR chapter 410 division 120, and SBHS 410-133-0140 in these rules, applicable to enrollment as a provider.

(2) Provide health services pursuant to the Medicaid-eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) for special education under OAR chapter 581, division 15.

(3) Provide health services using medically qualified staff (see 410-133-0120 Medically Qualified Staff in these rules).

(4) Provide appropriate medical supervision by licensed medically qualified staff consistent with their licensing board requirements.

(5) Document health services in writing as required in OAR 410-133-0320.

(6) Maintain adequate medical and financial records as part of the Medicaid-eligible student's education record necessary to fully disclose the extent of the covered health services provided.

(7) Make the records required by these rules and specifically OAR 410-133-0320 available for a period of seven years from the date of payment.

(8) Document costs and establish a schedule of cost rates per discipline in accordance with OAR 410-133-0245.

(9) Provide access for on-site review of IDEA Medicaid-eligible students' education records directly related to payments for claims to the SM provider for Medicaid covered health related services specified on an IEP or IFSP and furnish such information to any state or federal agency responsible for administration or oversight of the medical assistance program as the state or federal agency may from time to time request in compliance with OAR 943-120-0310.

(10) Document any changes in the Individualized Education Program/Individualized Family Service Plan (IEP/IFSP) related to the provision of Medicaid covered health services under School-Based Health Services (SBHS).

(11) Assure that SBHS services billed are billed in accordance with OAR 410-120-0035, reflect covered health services, and do not reimburse for non-covered education services or administrative activities.

(12) Retain the full payment amount for Medicaid-covered services provided.

(13) Utilize procedures to confirm that all individuals providing health services to Medicaid-eligible students, whether as employees or under contract with the SM provider, are eligible to provide Medicaid services and are not excluded from providing Medicaid services. Exclusion means the Authority will not reimburse an SM provider (allied agency) who employs a medically licensed individual who has defrauded or abused the Authority for items or services furnished by that individual. (See OAR 410-120-1400 Provider Sanctions, OAR 410-133-0120 Medically Qualified Staff, and 410-133-0200 Not Covered Services.).

(14) Comply with all applicable provisions of the Authority's rules chapter 943 division 120 and the Division General Rules Chapter 410 division 120, including rules related to the use of billing providers. If the SM provider seeks to submit claims to the Authority electronically, it must comply with the applicable provisions of the Department's Electronic Data Interchange (EDI) rules for EDI transactions OAR Chapter 943 Divsion120. EDI does not include electronic transmission by web portal.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 413.042 & 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 28-2008(Temp), f. 6-30-08, cert. ef. 7-1-08 thru 12-28-08; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0120
Medically Qualified Staff

(1) The school medical (SM) provider shall furnish covered health services through the medically qualified staff who provide health services within the scope of their licensure. The SM provider shall document the credentials and qualifications, updated periodically, of all medically qualified staff. The SM provider credential file shall document the manner in which the provider checked, and periodically re-checked, the Medicaid provider exclusion list to confirm that the medically qualified staff is eligible to provide health services to Medicaid-eligible students in compliance with provider enrollment agreement attachment OHP 3120. Special education teachers are not recognized as medically qualified staff for these services. See http://oig.hhs.gov/exclusions/index.asp.

(2) School-based health services are delivered by providers who meet the federal requirements listed below and who operate within the scope of their health care practitioner's license or certification pursuant to state law as follows:

(a) Evaluation and physical therapy treatments shall be provided by licensed physical therapists that meet the federal requirements of 42 CFR 440.110 and are licensed by the state Physical Therapist Licensing Board. Licensed physical therapists assistants whose function is to assist the physical therapist in patient-related activities and to perform delegated procedures that are commensurate with the licensed therapist assistant's education and training may provide therapy treatments under the supervision and direction of a state licensed physical therapist within the scope of the health care practitioner's license and accreditation pursuant to state law;

(b) Occupational therapy evaluation and treatments shall be provided by licensed occupational therapists that meet the federal requirements of 42 CFR 440.110 and are licensed by the state Occupational Therapy Licensing Board. Licensed occupational therapist assistants whose function is to assist the occupational therapist in patient-related activities and to perform delegated procedures that are commensurate with the licensed therapist assistant's education and training may provide therapy treatments under the supervision and direction of a state licensed occupational therapist within the scope of the health care practitioner's license and accreditation pursuant to state law;

(c) Speech therapy evaluation and treatments shall be provided by speech pathologists that meet the federal requirements at 42 CFR 440.110 and are licensed by the state Board of Examiners for Speech-Language Pathology and Audiology or hold a license issued by the Teacher Standards and Practice Commission (TSPC) prior July 1, 2016, exemption in ORS 681.230(4) pursuant to SB287 and hold a Certificate of Clinical Competency from the American Speech-Language-Hearing Association or has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate:

(A) Speech therapy services may be provided by a graduate speech pathologist being supervised in the Clinical Fellowship Year (CFY) and shall be provided in compliance with supervision requirements of the state licensing board and the American Speech-Language-Hearing Association (ASHA);

(B) A Certified Speech-Language Pathology Assistant (SLPA) performing within the scope of practice may provide therapy under the supervision of a state licensed speech-language pathologist within the scope of the health care practitioner's license and accreditation pursuant to state law meeting the requirements for speech pathologist as above described in (c). Excludes services described in OAR 335-095-0040, Qualifications for Supervising Speech-Language Pathology Assistants; see OAR 410-133-0200 Not Covered Services.

(d) Audiology evaluation and services shall be provided by audiologists that meet the federal requirements at 42 CFR 440.110;

(e) Nurse evaluation and treatments shall be provided by or under the direction of registered nurses (RN) licensed to practice in Oregon by the Oregon State Board of Nursing or nurse practitioners that meet the federal requirements at 42 CFR 440.166 and are licensed by the Oregon State Board of Nursing to practice in Oregon as a Nurse Practitioner (See Oregon State Board of Nursing Nurse Practice Act, OAR chapter 851 divisions 4547 and Nurse Practitioners, OAR chapter 851 division 050:

(A) Licensed practical nurses (LPN) may participate in the implementation of the plan of care for providing care to clients under the supervision of a licensed registered nurse, nurse practitioner, or physician pursuant to the Oregon State Board of Nursing Nurse Practice Act, OAR divisions 045 and 047;

(B) Treatment may also be provided by a delegated health care aide that is a non-licensed person trained and supervised by a licensed registered nurse (RN) or nurse practitioner (NP) to perform selected tasks of nursing care pursuant to the Oregon State Board of Nursing administrative rules, division 047 of the Nurse Practice Act.

(f) Psychological/mental health evaluations, testing, psychological services and treatments shall be provided by individuals who meet the relevant requirements of their respective professional state licensure as follows:

(A) Psychiatrists must be licensed to practice medicine and surgery in the State of Oregon and possess a valid license from the Oregon Medical Board;

(B) Psychologists must have one of the following: A doctoral degree in psychology obtained from an approved doctoral program in psychology accredited by the American Psychological Association (APA), a doctoral degree in psychology from a program at a college or university that is regionally accredited at the doctoral level that meets the requirements approved by the state Board of Psychologist Examiners (Board) by rule (see OAR Chapter 858 Division 10), and have two years of supervised employment under the direction of a psychologist licensed in Oregon or under the direction of a person considered by the board to have equivalent supervisory competence;

(C) Psychologists associates granted independent status by the Board for authority to function without immediate and direct supervision in compliance with OAR 858-010-0039. Until the psychologist associate successfully obtains independent status, the "psychologist associate resident" must not practice without immediate supervision, but must at all times be under the periodic direct supervision of a licensed psychologist or under the direction of a person considered by the board to have equivalent supervisory competency who shall continue to be responsible for the practice of the associate, see OAR 858-010-0037-through 858-010-0039;

(D) Psychologists associates who do not possess a doctoral degree and are deemed competent to perform certain functions within the practice of psychology under the periodic direct supervision of a psychologist licensed by the Board:

(i) Complied with all the applicable provisions of ORS 675.010 to 675.150;

(ii) Received a master's degree in psychology from a psychology program approved by the Board by rule;

(iii) Completed an internship in an approved educational institution or one year of other training experience acceptable to the Board, such as supervised professional experience under the direction of a psychologist licensed in Oregon or under the direction of a person considered by the Board to have equivalent supervisory competence; and

(iv) Furnishes proof acceptable to the Board of at least 36 months, exclusive of internship, of full-time experience satisfactory to the board under the direct supervision of a licensed psychologist in Oregon or under the direct supervision of a person considered by the Board to have equivalent supervisory competence.

(E) Testing technicians under the supervision of a licensed psychologist. A licensee may delegate administration and scoring of tests to technicians as provided in ORS 675.010(4) and OAR 858-010-0002;

(F) Services provided by Clinical Social Work Associate (CSWA) or Licensed Clinical Social Workers (LCSW): Must possess a master's degree from an accredited college or university accredited by the Council on Social Work Education and have completed the equivalent of two years of full-time experience in the field of clinical social work in accordance with rules of the Oregon State Board of Social Workers for a LCSW or whose plan of practice and supervision has been approved by the board for a CSWA working toward LCSW licensure under the supervision of a LCSW for two years of postmasters clinical experience and is licensed by the Board of Licensed Social Workers to practice in Oregon. See Board of Licensed Social Workers, chapter 877, division 20, Rules Applicable to Certification and Licensing.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042, 414.065

Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 49-1991(Temp), f. & cert. ef. 10-24-91; HR 3-1992, f. & cert. ef. 1-2-92; HR 29-1993, f. & cert. ef. 10-1-93; HR 19-1994, f. & cert. ef. 4-1-94; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 31-2003, f. & cert ef. 4-1-03 ; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0140

School Medical Provider Enrollment Provisions

(1) This rule applies only to providers seeking reimbursement from the Division, except as otherwise provided in OAR 410-120-1295.

(2) Only Educational Agency (EA) providers of SBHS that meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2005 will be enrolled with the Division as school medical (SM) providers allowed to seek reimbursement for the provision of covered health services pursuant to a Medicaid eligible child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

(3) The provider enrollment process will consist of: The completion and submission of the School Medical (SM) provider enrollment application and the required attachments, disclosure documents, and provider agreement with the Division of Medical Assistance Programs.

(4) An approved enrollment application by the Division or the Authority unit responsible for enrolling the SM provider is a contractual agreement that binds the SM provider to comply with the Authority administrative rules OAR 943-120-0300 through 943-120-0380, the Division General Rules 410-120-1260 and School-Based Health Services (SBHS) rules.

(5) Signing the SM provider agreement enclosed in the application package constitutes agreement by performing, and billing providers for provision of SBHS to comply with all applicable rules of the Medical Assistance Program and federal and state laws and regulations.

(6) An SM provider is a performing provider. A performing provider is the provider of a service or item. A billing provider is an individual, agent, business, corporation, clinic, group, institution, or other entity who in connection with the submission of claims to the Authority, receives or directs the payment (either in the name of the performing provider or the name of the billing provider) from the Authority, on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider (See OAR 410-120-1260):

(a) A billing provider is responsible for identifying to the Division and keeping current the identification of all performing providers for whom they bill, or receive or direct payments. This identification must include the providers' names, Authority provider numbers, NPIs, and either the performing provider's Social Security Number (SSN) or Employer Identification Number (EIN). The SSN or EIN of the performing provider cannot be the same as the Tax Identification Number (TIN) of the billing provider. In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements, the Authority requires billing providers to be enrolled consistent with the provider enrollment process described in OAR 410-120-1260(7);

(b) If the SM performing provider uses electronic media to conduct transactions with the Authority, or authorizes a billing provider to conduct such electronic transactions, the SM performing provider must comply with the Electronic Data Interchange (EDI). Enrollment as a SM performing provider or billing provider is a necessary requirement for submitting electronic claims, but the provider must also register as a trading partner and identify the EDI Submitter;

(c) A school medical (SM) performing provider that uses electronic media to conduct transaction with the Authority or authorizes a billing provider to conduct such electronic transactions, must comply with the electronic data interchange (EDI). Enrollment as an SM performing provider or billing provider is a necessary requirement for submitting electronic claims. If the SM provider intends to use an electronic data interchange (EDI) submitter, the SM performing provider must register with the Authority as a trading partner and shall complete the "Trading Partner Authorization of EDI Submitter" and the EDI submitter information required in the application in compliance with the trading partner requirements of identifying the authority of the EDI submitter to submit claims on its behalf. The EDI submitter must sign the EDI certification and meet other Authority EDI submission requirements pursuant to the EDI rules, before the Authority may accept an electronic submission from the EDI submitter on behalf of the performing provider. Information about the EDI transaction requirements is available on the Authority's web site.

(7) To be enrolled and able to bill as an SM provider, an EA, must meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations, and rules and must comply with all Oregon statutes and regulations for provision of Medicaid and State Children's Health Insurance program (SCHIP) services. In addition, all providers of services within the State of Oregon must have a valid Oregon business license if such a license is a requirement of the state, federal, county or city government to operate a business or to provide services.

(8) An EA, individual, or organization that is currently subject to sanction by the Medical Assistance Program or Federal government is not eligible for enrollment.

(9) The Authority requires compliance with the National Provider Identification (NPI) requirements in 45 CFR Part 142. Providers that obtain an NPI should update their records with the Division Provider Enrollment. Provider applicants that have been issued an NPI must include that NPI number with the Division provider enrollment application.

(10) A performing provider number will be issued to an EA providing covered health care services or items upon:

(a) Completion of the application and submission of the required School-Based Health Services SM Provider Attachment, disclosure documents, and provider agreement;

(b) The signing of the SM provider application by the authorized representative for the EA to bind the EA SM provider to compliance with these rules;

(c) Verification of licensing or certification. Loss of the appropriate licensure or certification or failure to meet the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2005 will result in immediate dis-enrollment of the provider and recovery of payments made subsequent to the loss of licensure or certification;

(d) Approval of the application and required documentation for an SM provider by the Division or the Division responsible for enrolling the provider.

(11) An SM performing provider may be enrolled retroactive to the date services were provided to a medical assistance client/child if:

(a) The SM provider met the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying such programs for state reimbursement under OAR 581-015-2005, was appropriately licensed, certified, and otherwise met all Medical Assistance Program requirements at the time services were provided; and

(b) Services were provided less than 12 months prior to the date of application for medical assistance provider status as evidenced by the first date stamped on the paper claims(s) submitted with application materials for those services either manually or electronically; or

(c) Extenuating circumstances existed outside the control of the EA SM provider consistent with federal Medicaid regulations, with approval of the Division's Provider Services Unit Manager.

(12) Issuance of an Authority-assigned SM provider number establishes enrollment of an EA as a provider for limited categories of services for the Medical Assistance Program applicable to the provision of Medicaid covered School-Based Health Services (SBHS).

(13) An SM provider is required for providing and continuing to provide to the Authority accurate, complete and truthful information regarding their qualification for enrollment. The SM provider is responsible for notifying the Division in writing of a material change in any status or condition that relates to their qualifications or eligibility to provide SBHS including but not limited to change in any of the following information: changes address, business affiliation, licensure, ownership, certification, NPI, billing agents or Federal Tax Identification Number (TIN), change in status for meeting the criteria for the provision of special education programs approved by the State Superintendent of Public Instruction qualifying the EA's programs for state reimbursement under OAR 581-015-2005, if the SM provider or a person with an ownership or control interest, or an agent or managing employee of the SM provider has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services program, the SM provider must notify the Division in writing within 30 calendar days of the change:

(a) Failure to notify the Division of a change of federal tax identification number (TIN) may result in the imposing of a $50 fine;

(b) Changes in business affiliation, ownership and control of information, criminal convictions, NPI, or federal tax identification number may require the submission of a new application;

(c) Payments made to providers who have not furnished such notification as required by this rule or to a provider that has failed to submit a new application as required by this rule and OAR 410-120-1260 may be denied or recovered.

(14) For information regarding enrollment of Billing Providers (BP) and issuance of an Authority assigned BP Provider ID in compliance with Provider Rules see OAR 943-120-0300 through 943-120-1505, 410-120-1260 and 943-120-0100 through 943-120-0200.

(15) Provider termination:

(a) The SM provider may terminate enrollment at any time. The request must be in writing, via certified mail, return receipt requested. The notice shall specify the provider number to be terminated and the effective date of termination. Termination of the SM provider enrollment does not terminate any obligations of the SM provider for dates of services during which the enrollment was in effect;

(b) The Division provider terminations or suspensions may be for, but are not limited to the following:

(A) Breaches of provider agreement;

(B) Failure to comply with the statutes, regulations and policies of the Authority, Federal and State regulations that are applicable to the provider;

(C) When no claims have been submitted in an 18-month period. The provider must reapply for enrollment.

(16) When one or more of the requirements governing a provider's participation in the medical assistance program are no longer met, the provider's medical assistance program provider number may be immediately suspended. The provider is entitled to a contested case hearing as outlined in 410-120-1600 to determine whether the provider's medical assistance program number will be revoked.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; OMAP 31-1998, f. & cert. ef. 9-1-98; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 43-2008, f. 12-17-08, cert. ef. 12-28-08; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0200
Not Covered Services

(1) Education-based costs normally incurred to operate a school and provide an education are not covered for payment by the Authority.

(2) Health services and treatment not documented on the Medicaid-eligible student's IEP or IFSP is not covered for payment by the Authority under the School-Based Health Services (SBHS) rules.

(3) Reviewing records (exception: reviewing records as part of an evaluation to establish, re-establish, or terminate a SBHS covered health service on a Medicaid-eligible student's IEP or IFSP).

(4) Meeting preparation.

(5) Health services preparation including materials preparation.

(6) Report writing (exception: report writing as part of preparation of initial evaluation and initial treatment plan to establish a covered health service on a Medicaid-eligible student's IEP or IFSP).

(7) Correspondence.

(8) Treatment and care coordination for an acute medical condition.

(9) Medication management not specific to mental health related services listed in the IEP/IFSP.

(10) Purchase of an assistive technology device is not covered through SBHS.

(11) Activities related to researching student names, determining Medical Assistance Program eligibility status, administrative activities such as data entry of billing claim forms, and travel time by service providers.

(12) Family therapy where the focus of treatment is the family.

(13) Routine health nursing services provided to all students by school nurses and nursing intervention for acute medical issues in the school setting, e.g., students who become ill or are injured.

(14) Educational workshops, training classes, and parent training workshops.

(15) Regular transportation services to and from school.

(16) Vocational services.

(17) Screening services.

(18) Evaluation services that are not performed by medically qualified staff within the scope of practice to establish, re-establish, or terminate a covered SBHS under IDEA.

(19) Service provided to non-Medicaid students in a group, class, or school free of charge. If only Medicaid-eligible students are charged for the service, the care is free, and Medicaid will not reimburse for the service. The free care limitation does not apply to health services provided as a result of an educational agency's obligation to provide FAPE services, and the health service is identified on the Medicaid-eligible student's IEP/IFSP. This means that school medical providers may bill for covered health services provided to Medicaid-eligible students under IDEA even though they may be provided to non-Medicaid-eligible students for free as a part of FAPE.

(20) Any non-medical unit of time spent on evaluations.

(21) Recreational services.

(22) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) comprehensive examinations described in OAR 410-130-0245 are not authorized to be provided by school medical providers.

(23) Services provided by an entity that employs an excluded provider. It is the obligation of the education agency to utilize the excluded provider web site to check for providers who have been excluded from receiving any monies affiliated with Medicaid and Medicare service reimbursements.

(24) Covered health services listed on an IEP or IFSP for those dates of service when the IEP/IFSP has lapsed.

(25) Covered health services that do not have a current recommendation by medically qualified staff within the scope of practice for the treatment provided as specified on the IEP or IFSP.

(26) Orientation and Mobility Training. Services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environments in school, home, and community.

(27) Using a rubber stamp to authenticate any entry for documentation of therapy provided to a student and billed to Medicaid for reimbursement for SBHS.

(28) Services provided by staff in an education setting licensed solely by the Teacher Standards and Practices Commission (TSPC). It is not sufficient for a state to use Department of Education provider qualifications for reimbursement of Medicaid-covered health services provided in an education setting.

(29) Services provided by speech-language pathology assistants in schools under the supervision of a speech-language pathologist who do not meet the requirements for a speech pathologist described in 410-133-0120 Medically Qualified Staff but instead holds either a basic, initial, standard, or continuing license in speech impaired issued by the Teacher Standards and Practices Commission and has obtained a permit from the Oregon Board of Examiners for Speech-Language Pathology and Audiology to supervise SLPA's in education settings under OAR 335-095-0055.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. &

cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0300
Procedure Codes

(1) The provider must use the procedure code from the School-Based Health Services table that best describes the specific service provided and a modifier that describes the discipline providing the service. Refer to 410-133-0080 Coverage for service requirements and limitations.

(2) Unit values equal 15 minutes of service unless otherwise stated. These time units must be documented in the Medicaid-eligible student's records under the services billed and accounted for under one code only.

(3) Visit. A service measurement of time for billing and reimbursement efficiency. One visit equals the school provider's hourly cost rate for category of service provided (i.e., occupational therapy, physical therapy, speech therapy, etc.) specified in an IEP or IFSP, divided by 60 to yield a cost per minute; per minute cost is then multiplied by amount of service time provided in minutes. For billing purposes, a visit is always presented as one visit.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 29-1993, f. & cert. ef. 10-1-93; HR 21-1995, f. & cert. ef. 12-1-95; OMAP 1-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 38-1999, f. & cert. ef. 10-1-99; OMAP 15-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

410-133-0320
Documentation and Record keeping Requirements

(1) Record keeping must conform and adhere to federal, state, and local laws and regulations.

(2) Records must record history taken, procedures performed, tests administered, results obtained, and conclusions and recommendations made. Documentation may be in the form of a "SOAP" (subjective objective assessment plan) note, or equivalent.

(3) Providers will retain information necessary to support claims submitted to the Authority including: documentation and supervision of the specific health services provided, the extent of the health service provided, the dates and the name and credentials of medically qualified staff who provided the service to the Medicaid-eligible student for seven years from date of payment. This documentation must meet the requirements of and must be made available pursuant to the requirements in the General Rules, OAR 410-120-1360 Requirements for Financial, Clinical and Other Records. These requirements may be met if the information is included in the IEP or IFSP and the school medical provider maintains adequate supporting documentation at the time the service is rendered, consistent with the requirements of OAR 410-120-1360:

(a) Supporting documentation should:

(A) Be accurate, complete, and legible;

(B) Be typed or recorded using ink;

(C) Be signed by the individual performing the service including their credentials or position;

(D) Be signed and initialed in accordance with licensing board requirements for each clinical entry by the individual performing the service;

(E) Be reviewed and authenticated by the supervising therapist in compliance with their licensing board requirements (Also see covered services 410-133-0080 and not covered services 410-133-0200.);

(F) Be for covered health services provided as specified for the service period indicated on the Medicaid-eligible student's current IEP or IFSP.

(b) Corrections to entries must be recorded by:

(A) Striking out the entry with a single line that does not obliterate the original entry or amend the electronic record preserving the original entry; and

(B) Dating and initialing the correction.

(c) Late entries or additions to entries shall be documented when the omission is discovered with the following written at the beginning of the entry: "late entry for (date)" or "addendum for (date)."

(4) Supporting documentation for Medicaid reimbursed health services described in a Medicaid-eligible student's IEP or IFSP must be kept for a period of seven years as part of the student's education record, which may be filed and kept separately by school health professionals and must include:

(a) A copy of the Medicaid-eligible student's IEP or IFSP as well as any addendum to the plan that correlates with the covered health services provided and reimbursed by Medicaid;

(b) A notation of the diagnosis or condition being treated or evaluated, using specific medical or mental health diagnostic codes;

(c) Results of analysis of any mental health or medical analysis, testing, evaluations, or assessments for which reimbursement is requested;

(d) Documentation of the location, duration, and extent of each health service provided, by the date of service, signed and initialed by medically qualified staff in accordance with their licensing board requirements (electronic records can be printed);

(e) The record of who performed the service and their credentials or position;

(f) The medical recommendation to support the service;

(g) Periodic evaluation of therapeutic value and progress of the Medicaid-eligible student to whom a health service is being provided;

(h) Record of medical need for necessary and appropriate transportation to a covered health service is supported by a transportation vehicle trip log including specific date transported, client name, ID number, and point of origin and destination consistent with transportation services specified in the child's IEP or IFSP as part of record-keeping requirements; and

(i) Attendance records for Medicaid-eligible students to support dates for covered services billed to Medicaid;

(j) In supervisory situations, the record documenting therapy provided must name both the assistant providing services and the supervising therapist including credentials. The licensed health care practitioner who supervises and monitors the assessment, care, or treatment rendered by licensed or certified therapy assistants shall meet the minimum standards required by their licensing board and shall co-sign for those services where appropriate with their name and professional titles (documentation may not be delegated except in emergency situations).

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 413.042 & 414.065
Hist.: HR 39-1991, f. & cert. ef. 9-16-91; HR 22-1995, f. & cert. ef. 12-1-95; OMAP 31-2003, f. & cert. ef. 4-1-03; OMAP 53-2003, f. 8-13-03 cert. ef. 9-1-03; OMAP 24-2005(Temp), f. & cert. ef. 4-5-05 thru 10-1-05; OMAP 53-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 19-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 33-2016, f. 6-29-16, cert. ef. 7-1-16

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Rule Caption: Defines Medicament in the Context of Dental Rules
Adm. Order No.: DMAP 34-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-123-1060
Subject: The Authority needs to define "medicament" in program rules to clarify that the word is being used in alignment with existing industry standards.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-123-1060
Definition of Terms

(1) "Anesthesia" The following depicts the Health System Division, Medical Assistance Programs' (Division) usage of certain anesthesia terms; however, for further details refer also to the Oregon Board of Dentistry administrative rules (OAR chapter 818, division 026):

(a) "Conscious Sedation" means the following:

(A) "Deep Sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance maintaining a patient airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained;

(B) "Minimal Sedation" means a minimally depressed level of consciousness produced by non-intravenous pharmacological methods that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method in minimal sedation;

(C) "Moderate Sedation" means a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(b) "General Anesthesia" means a drug-induced loss of consciousness during which the patient is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patient airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired;

(c) "Local Anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug;

(d) "Nitrous Oxide Sedation" means an induced controlled state of minimal sedation produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(2) Citizen/Alien-Waived Emergency Medical (CAWEM). Refer to OAR 410-120-0000 for definition of clients who are eligible for limited emergency services under the CAWEM benefit package. The definition of emergency services does not apply to CAWEM clients. OAR 410-120-1210 provides a complete description of limited emergency coverage pertaining to the CAWEM benefit package.

(3) "Covered Services" means services on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) that have been funded by the legislature and identified in specific program rules. Services are limited as directed by General Rules Excluded Services and Limitations (OAR 410-120-1200), the Division's Dental Services Program rules (chapter 410, division 123), and the Prioritized List. Services that are not considered emergency dental services as defined by section (12) of this rule are considered routine services.

(4) "Dental Hygienist" means an individual licensed to practice dental hygiene pursuant to state law.

(5) "Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH)" means an individual licensed to practice dental hygiene with an EPDH permit issued by the Board of Dentistry and within the scope of an EPDH permit pursuant to state law.

(6) "Dental Practitioner" means an individual licensed pursuant to state law to engage in the provision of dental services within the scope of the practitioner's license and certification.

(7) "Dental Services" means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist or denture services provided within the scope of practice as defined under state law by a denturist.

(8) "Dental Services Documentation" means meeting the requirements of the Oregon Dental Practice Act statutes; administrative rules for client records and requirements of OAR 410-120-1360 Requirements for Financial, Clinical and Other Records, and any other documentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).

(9) "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, evidence-based medicine, and professional standards of care as effective;

(c) Not solely for the convenience of an OHP member or a provider of the service; and

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a member.

(10) "Dentist" means an individual licensed to practice dentistry pursuant to state law.

(11) "Denturist" means an individual licensed to practice denture technology pursuant to state law.

(12) "Direct Pulp Cap" means the procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.

(13) Emergency Services means:

(a) Covered services for an emergency dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. This includes services to treat the following conditions:

(A) Acute infection;

(B) Acute abscesses;

(C) Severe tooth pain;

(D) Unusual swelling of the face or gums; or

(E) A tooth that has been avulsed (knocked out).

(b) The treatment of an emergency dental condition is limited only to covered services. The Division recognizes that some non-covered services may meet the criteria of treatment for the emergency condition; however, this rule does not extend to those non-covered services. Routine dental treatment or treatment of incipient decay does not constitute emergency care (See also OAR 410-120-0000).

(14) "Hospital Dentistry" means dental services normally done in a dental office setting but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical center, inpatient or outpatient hospital setting under general anesthesia, or IV conscious sedation, if appropriate.

(15) "Medical Practitioner" means an individual licensed pursuant to state law to engage in the provision of medical services within the scope of the practitioner's license and certification.

(16) "Medicament" means a substance or combination of substances intended to be pharmacologically active, specially prepared to be prescribed, dispensed, or administered to prevent or treat disease.

(17) "Procedure Codes" means the procedure codes set forth in OAR chapter 410, division 123 that refer to Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rule and other documents incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.

(18) "Standard of Care" means what reasonable and prudent practitioners would do in the same or similar circumstances.

Stat. Auth.: ORS 413.042, 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; 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 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; 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 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 36-2014, f. & cert. ef. 6-27-14; DMAP 34-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Amending Prior Authorization Approval Criteria Guide
Adm. Order No.: DMAP 35-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 410-121-0040
Subject: The Pharmaceutical Services Program administrative rules (Division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

The Authority is amending this rule to update the Oregon Medicaid Fee for Service Prior Authorization Criteria Guide found at http://www.oregon.gov/oha/healthplan/Pages/pharmacy-policy.aspx based on the P&T (Pharmacy and Therapeutic) Committee recommendations.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-121-0040
Prior Authorization Required for Drugs and Products

(1) Prescribing practitioners shall obtain prior authorization (PA) for the drugs and categories of drugs requiring PA in this rule, using the procedures set forth in OAR 410-121-0060.

(2) All drugs and categories of drugs including, but not limited to, those drugs and categories of drugs that require PA shall meet the following requirements for coverage:

(a) Each drug shall be prescribed for conditions funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services (OAR 410-141-0480 through 410-141-0520). If the medication is for a non-covered diagnosis, the medication may not be covered unless there is a co-morbid condition for which coverage would be allowed. The use of the medication shall meet corresponding treatment guidelines and be included within the client's benefit package of covered services and not otherwise excluded or limited;

(b) Each drug shall also meet other criteria applicable to the drug or category of drug in these pharmacy provider rules, including PA requirements imposed in this rule.

(3) The Authority may require PA for individual drugs and categories of drugs to ensure that the drugs prescribed are indicated for conditions funded by OHP and consistent with the Prioritized List of Health Services and its corresponding treatment guidelines (see OAR 410-141-0480). The

drugs and categories of drugs that the Authority requires PA for this purpose are found in the Oregon Medicaid Fee-for-Service Prior Authorization Approval Criteria (PA Criteria guide) dated July 1, 2016, adopted and incorporated by reference and found at: http://www.oregon.gov/OHA/healthplan/pages/pharmacy-policy.aspx.

(4) The Authority may require PA for individual drugs and categories of drugs to ensure medically appropriate use or to address potential client safety risk associated with the particular drug or category of drug, as recommended by the Pharmacy & Therapeutics Committee (P&T) and adopted by the Authority in this rule. The drugs and categories of drugs for which the Authority requires PA for this purpose are found in the Pharmacy PA Criteria Guide.

(5) New drugs shall be evaluated when added to the weekly upload of the First Databank drug file:

(a) If the new drug is in a class where current PA criteria apply, all associated PA criteria shall be required at the time of the drug file load;

(b) If the new drug is indicated for a condition below the funding line on the Prioritized List of Health Services, PA shall be required to ensure that the drug is prescribed for a condition funded by OHP;

(c) PA criteria for all new drugs shall be reviewed by the DUR/P&T Committee.

(6) PA shall be obtained for brand name drugs that have two or more generically equivalent products available and that are not determined Narrow Therapeutic Index drugs by the DUR/P&T Committee:

(a) Immunosuppressant drugs used in connection with an organ transplant shall be evaluated for narrow therapeutic index within 180 days after United States patent expiration;

(b) Manufacturers of immunosuppressant drugs used in connection with an organ transplant shall notify the Authority of patent expiration within 30 days of patent expiration for section (5)(a) to apply;

(c) Criteria for approval are:

(A) If criteria established in section (3) or (4) of this rule applies, follow that criteria;

(B) If section (6)(A) does not apply, the prescribing practitioner shall document that the use of the generically equivalent drug is medically contraindicated and provide evidence that either the drug has been used and has failed or that its use is contraindicated based on evidence-based peer reviewed literature that is appropriate to the client's medical condition.

(7) PA shall be obtained for non-preferred Preferred Drug List (PDL) products in a class evaluated for the PDL except in the following cases:

(a) The drug is a mental health drug as defined in OAR 410-121-0000;

(b) The original prescription is written prior to 1/1/10;

(c) The prescription is a refill for the treatment of seizures, cancer, HIV, or AIDS; or

(d) The prescription is a refill of an immunosuppressant.

(8) PA may not be required:

(a) When the prescription ingredient cost plus the dispensing fee is less than the PA processing fees as determined by the Authority;

(b) For over-the-counter (OTC) covered drugs when prescribed for conditions covered under OHP; or

(c) If a drug is in a class not evaluated from the Practitioner-Managed Prescription Drug Plan under ORS 414.334.

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.330 to 414.414, 414.312 & 414.316
Stats. Implemented: 414.065, 414.334, 414.361, 414.371, 414.353 & 414.354
Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 2-1990, f. & cert. ef. 1-16-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0170; HR 10-1991, f. & cert. ef. 2-19-91; HR 14-1993, f. & cert. ef. 7-2-93; HR 25-1994, f. & cert. ef. 7-1-94; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 18-1996(Temp), f. & cert. ef. 10-1-96; HR 8-1997, f. 3-13-97, cert. ef. 3-15-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2002, f. & cert. ef. 10-1-02; OMAP 66-2002, f. 10-31-02, cert. ef. 11-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 87-2003(Temp), f. & cert. ef. 12-15-03 thru 5-15-04; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 71-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 74-2004, f. 9-23-04, cert. ef. 10-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 4-2006(Temp), f. & cert. ef. 3-15-06 thru 9-7-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 41-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 9-2008, f. 3-31-08, cert. ef. 4-1-08; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 14-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 27-2011(Temp), f. & cert. ef. 9-30-11 thru 3-15-12; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 18-2012, f. 3-30-12, cert. ef. 4-9-12; DMAP 23-2012(Temp), f. & cert. ef. 4-20-12 thru 10-15-12; DMAP 27-2012(Temp), f. & cert. ef. 5-14-12 thru 10-15-12; DMAP 29-2012, f. & cert. ef. 6-21-12; DMAP 33-2012(Temp), f. 7-18-12, cert. ef. 7-23-12 thru 1-18-13; DMAP 40-2012(Temp), f. & cert. ef. 8-20-12 thru 1-18-13; DMAP 44-2012(Temp), f. & cert. ef. 9-26-12 thru 1-18-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 6-2013(Temp), f. & cert. ef. 2-21-13 thru 8-19-13; DMAP 23-2013(Temp), f. 4-30-13, cert. ef. 5-1-13 thru 8-19-13; Administrative correction, 7-18-13; DMAP 43-2013, f. & cert. ef. 8-16-13; DMAP 76-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 14-2014(Temp), f. & cert. ef. 3-21-14 thru 9-17-14; DMAP 27-2014(Temp), f. & cert. ef. 5-2-14 thru 6-30-14; DMAP 38-2014, f. & cert. ef. 6-30-14; DMAP 46-2014(Temp), f. & cert. ef. 7-15-14 thru 1-11-15; DMAP 49-2014(Temp), f. & cert. ef. 8-13-14 thru 1-11-15; DMAP 62-2014(Temp), f. 10-13-14, cert. ef. 10-14-14 thru 1-11-15; DMAP 75-2014, f. & cert. ef. 12-12-14; DMAP 76-2014(Temp), f. & cert. ef. 12-12-14 thru 6-7-15; DMAP 89-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-26-15; DMAP 4-2015(Temp), f. & cert. ef. 2-3-15 thru 6-26-15; DMAP 25-2015(Temp), f. 4-17-15, cert. ef. 4-18-15 thru 6-26-15; DMAP 34-2015, f. 6-25-15, cert. ef 6-26-15; DMAP 36-2015(Temp), f. 6-26-15, cert. ef. 7-1-15 thru 12-27-15; DMAP 41-2015(Temp), f. & cert. ef. 8-7-15 thru 2-2-16; DMAP 44-2015(Temp), f. 8-21-15, cert. ef. 8-25-15 thru 12-27-15; DMAP 58-2015(Temp), f. & cert. ef. 10-9-15 thru 12-27-15; DMAP 80-2015, f. 12-23-15, cert. ef. 12-27-15; DMAP 83-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 6-2016(Temp), f. 2-11-16, cert. ef. 2-12-16 thru 6-28-16; DMAP 19-2016(Temp), f. 4-28-16, cert. ef. 5-1-16 thru 6-28-16; DMAP 26-2016, f. 6-24-16, cert. ef. 6-28-16; DMAP 35-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Update Reference to Current Covered and Non-Covered Dental Services Document, Incorporate Changes and Corrections
Adm. Order No.: DMAP 36-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-123-1260
Rules Repealed: 410-123-1260(T)
Subject: The amendment of OAR 410-123-1260 is needed to align the administrative rule to reflect recent changes to the Prioritized List of Health Services and the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature (CDT Codes). Effective January 1, 2016, the Health Evidence Review Commission (HERC) added five oral health procedure codes to funded lines of the Prioritized List of Health Services. Four of these codes are either diagnostic or are payable dependent on other codes. The HERC also added a guideline to one of the codes, which this amendment reflects. In addition, the ADA deleted five CDT Codes that were on the prioritized list. Those changes are reflected in this amendment. The Authority needs to spell out in rule how the Oregon Health Plan will cover a newly opened CDT code. This will allow dentists to bill for two yearly applications of silver diamine fluoride, and the rule outlines exceptions.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-123-1260
OHP 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 include, but are not limited to:

(i) Dental screening services for eligible EPSDT individuals; and

(ii) Dental diagnosis and treatment that 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 shall provide EPSDT services for eligible Division of Medical Assistance Programs (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's Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at www.oregon.gov/oha/healthplan/Pages/dental.aspx.

(b) Restorative, periodontal, and prosthetic treatments:

(A) Documentation shall be included in the client's charts to support the treatment. Treatments shall be consistent with the prevailing standard of care 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) ENHANCED ORAL HEALTH SERVICES IN PRIMARY CARE SETTINGS:

(a) Topical fluoride treatment:

(A) For children under 19 years of age, topical fluoride varnish may be applied by a licensed medical practitioner during a medical visit. Providers must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with either the appropriate Current Dental Terminology (CDT) code (D1206-Topical Fluoride Varnish) or the appropriate Current Procedural Terminology (CPT) code (99188 - Application of topical fluoride varnish by a physician or other qualified health care professional).

(B) Topical fluoride treatment from a medical practitioner counts toward the overall maximum number of fluoride treatments, as described in subsection (4) of this rule.

(b) Assessment of a patient:

(A) For children under six years of age, CDT code D0191-Assessment of a Patient is covered as an enhanced oral health service in medical settings;

(B) For reimbursement in a medical setting, D0191-Assessment of a patient must include all of the following components:

(i) Caries risk assessment using a standardized tool endorsed by Oregon Oral Health Coalition, the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics;

(ii) Anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;

(iii) Referral to a dentist in order to establish a dental home;

(iv) Documentation in medical chart of risk assessment findings and service components provided.

(C) For reimbursement, the performing provider must meet all of the following criteria:

(i) Be a physician (MD or DO), an advance practice nurse, or a licensed physician assistant; and

(ii) Hold a certificate of completion from one of the following approved training programs within the previous three years:

(I) Smiles for Life; or

(II) First Tooth through the Oregon Oral Health Coalition.

(D) For reimbursement, the medical practitioners must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with the appropriate CDT code (D0191-Assessment of a Patient).

(E) D0191 Assessment of a Patient may be reimbursed under this subsection up to a maximum of once every 12 months;

(F) D0191 Assessment of a Patient from a medical practitioner does not count toward the maximum number of CDT code D0191-Assessment of a Patient services performed by a dental practitioner described in subsection three (3) of this rule.

(c) For tobacco cessation services provided during a medical visit, follow criteria outlined in OAR 410-130-0190.

(3) DIAGNOSTIC SERVICES:

(a) Exams:

(A) For children under 19 years of age:

(i) The Division shall reimburse exams (billed as CDT codes 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 CDT codes 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 must not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams performed 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 performed by a dental hygienist (with or without an expanded practice permit).

(b) Assessment 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. Assessment of a patient (D0191) is included as part of an exam (D0120-D0180);

(iv) For children under 19 years of age, a maximum of twice every 12 months; and

(v) For adults age 19 and older, a maximum of once every 12 months.

(B) 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 shall 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 ten periapicals and two bitewings for a total of 12 films;

(ii) For clients ages 12 and older - a minimum of ten 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 is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records shall be included in the client's records;

(K) Digital radiographs, if printed, shall be on photo paper to assure sufficient quality of images.

(4) 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 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) Additional topical fluoride treatments may be available, up to a total of four treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for 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 years 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.

(D) Fluoride 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 ten services within a three-month period.

(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.

(f) Interim caries arresting medicament application (D1354):

(A) Is limited to silver diamine fluoride (SDF) application as the medicament. It does not include coverage of any other medicaments;

(B) May not be billed for more than two applications per year;

(C) Requires that the tooth or teeth numbers be included on the claim;

(D) Shall be covered with topical application of fluoride (D1206 or D1208) when they are performed on the same date of service if D1354 is being used to treat a carious lesion and D1206 or D1208 to prevent caries;

(E) Shall be covered with an interim therapeutic restoration (D2941) or a permanent restoration and (D1354) on the same tooth, when dentally appropriate.

(5) RESTORATIVE SERVICES:

(a) Amalgam and resin-based composite restorations, direct:

(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;

(B) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;

(C) 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 shall 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) Interim therapeutic restoration on primary dentition (D2941) is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration;

(H) Reattachment of tooth fragment (D2921) is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;

(I) The Division reimburses for a surface not more than once in each treatment episode regardless of the number or combination of restorations;

(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.

(b) Indirect 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 percent of the tooth structure must be remaining for coverage of the core buildup;

(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 the following only for clients under 21 years of age or who are pregnant:

(i) Prefabricated plastic crowns (D2932) are allowed only for anterior teeth, permanent or primary;

(ii) Stainless steel crowns (D2930/D2931) are allowed only for anterior primary teeth and posterior permanent or primary teeth;

(iii) Prefabricated stainless steel crowns with resin window (D2933) are 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) shall 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 410-123-1100 Services Reviewed by the Division);

(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 millimeters and over, documentation shall 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 the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture shall have favorable expected long-term prognosis.

(D) 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.

(E) Crown repair (D2980) is limited to only anterior teeth.

(6) ENDODONTIC SERVICES:

(a) 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.

(b) Endodontic retreatment and apicoectomy:

(A) The Division does not cover retreatment of a previous root canal or apicoectomy 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.

(c) 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;

(d) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;

(e) Apexification/recalcification procedures:

(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;

(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant.

(7) 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 gingivoplasty 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 two 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 increased periodontal maintenance (chart notes, pocket depths and radiographs).

(d) Records shall 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).

(8) 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 shall 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 shall 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 mastication. Third molars are not a consideration when counting missing teeth;

(D) The dental practitioner shall 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 shall 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 ten (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 the 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 or 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 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 four 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 two 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 (D5670, D5671):

(A) Is covered for clients age 16 and older a maximum of once every ten (10) years, per arch;

(B) Ten years or more shall 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 ten 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 shall be documentation of a current reline that 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 five 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.

(9) 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 shall 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.

(10) 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 condition or diagnosis, 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 or 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 ICD-10 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 or 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 shall 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, 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.

(11) ORTHODONTIA SERVICES:

(a) The Division limits orthodontia services and extractions to eligible clients:

(A) With the ICD-10-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 shall be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record shall 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 shall 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.

(12) 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 (D9223 and D9243);

(B) The Division reimburses providers for general anesthesia or IV sedation as follows:

(i) D9223 or D9243: For each 15-minute period, up to three and a half hours on the same day of service.

(ii) 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 shall 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

Stats. Implemented: ORS 414.065

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; DMAP 68-2013, f. 12-5-13, cert. ef. 12-23-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 10-2014(Temp), f. & cert. ef. 2-28-14 thru 8-27-14; DMAP 19-2014(Temp), f. 3-28-14, cert. ef. 4-1-14 thru 6-30-14; DMAP 36-2014, f. & cert. ef. 6-27-14; DMAP 56-2014, f. 9-26-14, cert. ef. 10-1-14; DMAP 7-2015(Temp), f. & cert. ef. 2-17-15 thru 8-15-15; DMAP 28-2015, f. & cert. ef. 5-1-15; DMAP 46-2015(Temp), f. 8-26-15, cert. ef. 10-1-15 thru 3-28-16; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 65-2015, f. 11-3-15, cert. ef. 12-1-15; DMAP 74-2015(Temp), f. 12-18-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 5-2016(Temp), f. & cert. ef. 2-9-16 thru 6-28-16; DMAP 36-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: HERC Prioritized List Effective July 1, 2016
Adm. Order No.: DMAP 37-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 410-141-0520
Subject: The OHP program administrative rules govern the Division's payments for services provided to clients. The Authority is temporarily amending 410-141-0520. This change references the approved Health Evidence Review Commission (HERC) Prioritized List of Health Services, incorporating by reference new modifications effective July 1, 2016, to the Centers for Medicare and Medicaid Services' (CMS) approved biennial January 1, 2016-December 31, 2017, Prioritized List of condition treatment pairs funded through line 475, including interim modifications approved at the October 1, 2015, and November 12, 2015, HERC meetings. The July 1, 2016, Prioritized List includes previously delayed changes to the Prioritized List involving the treatments for conditions of the back and spine. (Implementation of these changes had been delayed from its original planned date of January 1, 2016.) In addition, several new interim modifications are included that were approved at the January 14, 2016, and May 19, 2016, HERC meetings, which represent conforming changes involving the pairing of treatments for conditions of the back and spine.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-0520
Prioritized List of Health Services

(1) The Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) is the listing of physical and mental health services with "expanded definitions" of practice guidelines and statements of intent as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HERC. The HERC maintains the most current list on their website: http://www.oregon.gov/oha/herc/Pages/index.aspx. For a hard copy, contact the Division within the Oregon Health Authority (Authority).

(2) This rule incorporates by reference new modifications effective July 1, 2016, to the Centers for Medicare and Medicaid Services' (CMS) approved biennial January 1, 2016–December 31, 2017, Prioritized List of condition treatment pairs funded through line 475, including interim modifications approved at the October 1, 2015, and November 12, 2015, HERC meetings. The July 1, 2016, Prioritized List includes previously delayed changes to the Prioritized List involving the treatments for conditions of the back and spine. (Implementation of these changes had been delayed from its original planned date of January 1, 2016.) In addition, several new interim modifications are included that were approved at the January 14, 2016, and May 19, 2016, HERC meetings, which represent conforming changes involving the pairing of treatments for conditions of the back and spine.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065 & 414.727
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 33-1998, f. & cert. ef. 9-1-98; OMAP 40-1998(Temp), f. & cert. ef. 10-1-98 thru 3-1-99; OMAP 48-1998(Temp), f. & cert. ef. 12-1-98 thru 5-1-99; OMAP 21-1999, f. & cert. ef. 4-1-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 9-2000(Temp), f. 4-27-00, cert. ef. 4-27-00 thru 9-26-00; OMAP 13-2000, f. & cert. ef. 9-12-00; OMAP 14-2000(Temp), f. 9-15-00, cert. ef. 10-1-00 thru 3-30-01; OMAP 40-2000, f. 11-17-00, cert. ef. 11-20-00; OMAP 22-2001(Temp), f. 3-30-01, cert. ef. 4-1-01 thru 9-1-01; OMAP 28-2001, f. & cert. ef. 8-10-01; OMAP 53-2001, f. & cert. ef. 10-1-01; OMAP 18-2002, f. 4-15-02, cert. ef. 5-1-02; OMAP 64-2002, f. & cert. ef. f. & cert. ef. 10-2-02; OMAP 65-2002(Temp), f. & cert. ef. 10-2-02 thru 3-15-0; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 30-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04; OMAP 17-2004(Temp), f. 3-15-04 cert. ef. 4-1-04 thru 9-15-04; OMAP 28-2004, f. 4-22-04 cert. ef. 5-1-04; OMAP 48-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 51-2004, f. 9-9-04, cert. ef. 10-1-04; OMAP 68-2004(Temp), f. 9-14-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 83-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 54-2005(Temp), f. & cert. ef. 10-14-05 thru 4-1-06; OMAP 62-2005, f. 11-29-05, cert. ef. 12-1-05; OMAP 71-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 6-2006, f. 3-22-06, cert. ef. 4-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 14-2007(Temp), f. & cert. ef. 10-1-07 thru 3-28-08; DMAP 28-2007(Temp), f. & cert. ef. 12-20-07 thru 3-28-08; DMAP 8-2008, f & cert. ef. 3-27-08; DMAP 10-2008(Temp), f. & cert. ef. 4-1-08 thru 9-15-08; DMAP 23-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 31-2008(Temp), f. & cert. ef. 10-1-08 thru 3-29-09; DMAP 40-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 4-2009(Temp), f. & cert. ef. 1-30-09 thru 6-25-09; DMAP 6-2009(Temp), f. 3-26-09, cert. ef. 4-1-09 thru 9-25-09; DMAP 8-2009(Temp), f. & cert. ef. 4-17-09 thru 9-25-09; DMAP 26-2009, f. 8-3-09, cert. ef. 8-5-09; DMAP 30-2009(Temp), f. 9-15-09, cert. ef. 10-1-09 thru 3-29-10; DMAP 36-2009(Temp), f. 12-10-09 ef. 1-1-10 thru 3-29-10; DMAP 1-2010(Temp), f. & cert. ef. 1-15-10 thru 3-29-10; DMAP 3-2010, f. 3-5-10, cert. ef. 3-17-10; DMAP 5-2010(Temp), f. 3-26-10, cert. ef. 4-1-10 thru 9-1-10; DMAP 10-2010, f. & cert. ef. 4-26-10; DMAP 27-2010(Temp), f. 9-24-10, cert. ef. 10-1-10 thru 3-25-11; DMAP 43-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 4-2011, f. 3-23-11, cert. ef. 4-1-11; DMAP 24-2011(Temp), f. 9-15-11, cert. ef. 10-1-11 thru 3-26-12; DMAP 45-2011, f. 12-21-11, cert. ef. 12-23-11; DMAP 47-2011(Temp), f. 12-13-11, cert. ef. 1-1-12 thru 6-25-12; DMAP 22-2012(Temp), f. 3-30-12, cert. ef. 4-1-12 thru 9-21-12; DMAP 43-2012(Temp), f. 9-21-12, cert. ef. 9-23-12 thru 3-21-13; DMAP 11-2013, f. & cert. ef. 3-21-13; DMAP 50-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 57-2013(Temp), f. & cert. ef. 10-29-13 thru 3-30-14; DMAP 7-2014, f. & cert. ef. 1-31-14; DMAP 13-2014(Temp), f. 3-20-14, cert. ef. 4-1-14 thru 9-28-14; DMAP 31-2014, f. 5-30-14, cert. ef. 7-1-14; DMAP 63-2014(Temp), f. & cert. ef. 10-17-14 thru 12-31-14; DMAP 79-2014, f. 12-18-14, cert. ef. 12-31-14; DMAP 80-2014(Temp), f. 12-23-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 18-2015, f. & cert. ef. 4-1-15; DMAP 50-2015(Temp), f. 9-10-15, cert. ef. 10-1-15 thru 3-28-16; DMAP 75-2015(Temp), f. 12-22-15, cert. ef. 1-1-16 thru 6-13-16; DMAP 10-2016, f. 2-24-16, cert. ef. 3-1-16; DMAP 37-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: CCO Substance Use Disorder Provider, Treatment and Facility Certification and Licensure
Adm. Order No.: DMAP 38-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Adopted: 410-141-3110
Subject: The Authority needs a rule to address Substance Use Disorder (SUD) Provider, Treatment and Facility Certification and Licensure as they fit into the coordinated care organizational framework. This rule specifies the regulations that provide such a framework for certification and licensure for the SUD program.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-3110
CCO Substance Use Disorder Provider, Treatment and Facility Certification and Licensure

(1) Certain Behavioral Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP), or authorized Coordinated Care Organization (CCO).

(2) Substance Use Disorder (SUD) treatment services are covered for eligible OHP clients when provided by a CCO:

(a) Outpatient substance use disorder providers that are facilities or agencies shall have a certificate issued by the Authority as described in OAR 415-012-0000 for the scope of services provided;

(b) Any facility that meets the definition of a residential treatment facility for substance-dependent persons under ORS 430.010 and 443.400 or detoxification center as defined in ORS 430.306 shall be licensed by the Authority as described in OAR 415-012-0000 for the scope of service provided;

(c) Synthetic opioid treatment programs shall meet the requirements described in OAR 415-020-0000;

(d) Detoxification centers shall have a license issued by the Authority as described in OAR 415-012-0000 and 415-050-0000 for the scope provided.

Stat. Auth.: ORS 192.527, 192.528, 413.042 & 414.065
Stat. Implemented: ORS 192.527, 192.528, 413.042, 414010, 414.065 & 414.727
Hist.: DMAP 38-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Definition Addition of Managed Care Entity (MCE)
Adm. Order No.: DMAP 39-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-141-0000
Subject: In order to find a singular term that could be used to represent all plan types in Medicaid rule language and in an effort to be compliant with the term, the Authority sought guidance from CMS with particular consideration given to the new managed care rules. The response received from CMS: To your question, Managed Care Entity (MCE) is a definition that can be used to encompass multiple organizations, plans, etc., (in your/Oregon's case CCO, DCO, MHO). Managed Care Entity is currently defined at 42 CFR 457.10: Managed care entity (MCE) means an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers. Link to 42 CFR 457.10: http://www.ecfr.gov/cgi-bin/text-idx?SID=c5cba4e2e28a4c186d3c4a075f239285&mc=true&node=se42.4.457_110&rgn=div8. It is the Authority's intent to use the term "managed care entity (MCE)" starting with OAR 410-141-0000 to house the definition referenced above. There have also been two cross references directing the reader to OAR 410-120-0000 added for the terms "client" and "member."
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-0000
Definitions

In addition to the definitions in OAR 410-120-0000, the following definitions apply:

(1) "Action" means in the case of a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):

(a) The denial or limited authorization of a requested service including the type or level of service;

(b) The reduction, suspension, or termination of a previously authorized service;

(c) The denial in whole or in part of payment for a service;

(d) The failure to provide services in a timely manner as defined by the Health Systems Division, Medical Assistance Programs (Division);

(e) The failure of a PHP or CCO to act within the timeframes provided in 42 CFR 438.408(b); or

(f) For a member who resides in a rural service area where the PHP or CCO is the only PHP or CCO, the denial of a request to obtain covered services outside of the PHP or CCO provider network under any of the following circumstances:

(A) From any other provider (in terms of training, experience, and specialization) not available within the network;

(B) From a provider not part of the network that is the main source of a service to the member as long as the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days;

(C) Because the only plan or provider available does not provide the service due to moral or religious objections;

(D) Because the member's provider determines the member needs related services that would subject the member to unnecessary risk if received separately, and not all related services are available within the network; or

(E) The Authority determines that other circumstances warrant out-of-network treatment for moral or religious objections.

(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final CCO or MCO claims decision or the Authority issuing a final hearings decision. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.

(3) "Capitated Services" means those covered services that a PHP agrees to provide for a capitation payment under contract with the Authority.

(4) "Capitation Payment" means monthly prepayment to a PHP for health services the PHP provides to members.

(5) "CCO Payment" means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.

(6) "Certificate of Authority" means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.

(7) "Client" has the meaning given that term in OAR 410-120-0000.

(8) "Cold Call Marketing" means a PCP's or CCO's unsolicited personal contact with a potential member for the purpose of marketing.

(9) "Community Advisory Council" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625.

(10) "Community Standard" means typical expectations for access to the health care delivery system in the member's community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members in PHPs take into consideration the community standard and be adequate to meet the needs of the Division.

(11) "Contract" means an agreement between the State of Oregon acting by and through the Authority and a PHP or CCO to provide health services to eligible members.

(12) "Converting MCO" means a CCO that:

(a) Is the legal entity that contracted as an MCO with the Authority as of July 1, 2011, or;

(b) Was formed by one or more MCOs that contracted with the Authority as of July 1, 2011.

(13) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.

(14) "Coordinated Care Services" mean a CCO's fully integrated physical health, behavioral health services pursuant to ORS 414.651, and dental health services pursuant to ORS 414.625(3) that a CCO agrees to provide under contract with the Authority.

(15) "Corrective Action or Corrective Action Plan" means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

(16) "Dental Care Organization (DCO)" means a PHP that provides and coordinates dental services as capitated services under OHP.

(17) "Dental Case Management Services" means services provided to ensure the member receives dental services including a comprehensive, ongoing assessment of the member's dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.

(18) "DCBS Reporting CCO" means for the purpose of OAR 410-141-3340 through 410-141-3395 a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.

(19) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection agency.

(20) "Disenrollment" means the act of removing a member from enrollment with a PHP or CCO.

(21) "Exceptional Needs Care Coordination (ENCC)" means for PHPs a specialized case management service provided by FCHPs to members identified as aged, blind, or disabled who have complex medical needs, consistent with OAR 410-141-0405. ENCC includes:

(a) Early identification of those members who are aged, blind, or disabled who have complex medical needs;

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of capitated services and discharge planning; and

(e) Aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.

(22) "Enrollment" means the assignment of a member to a PHP or CCO for management and receipt of health services.

(23) "Free-Standing Mental Health Organization (MHO)" means the single MHO in each county that provides only behavioral services and is not affiliated with a fully capitated health plan for that service area.

(24) "Fully-Capitated Health Plan (FCHP)" means PHPs that contract with the Authority to provide capitated health services including inpatient hospitalization.

(25) "Global Budget" means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.

(26) "Grievance" means a member's complaint to a PHP, CCO, or to a participating provider about any matter other than an action.

(27) "Grievance System" means the overall system that includes:

(a) Grievances to a PHP or CCO on matters other than actions;

(b) Appeals to a PHP or CCO on actions; and

(c) Contested case hearings through the state on actions and other matters for which the member is given the right to a hearing by rule or state statute.

(28) "Health Services" means:

(a) For purposes of CCOs, the integrated services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health that includes mental health and substance use disorders, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services;

(b) For all other purposes, the services authorized to be provided within the medical assistance program as defined in ORS 414.025 for the physical medical, behavioral health, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.

(29) "Holistic Care" means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, especially one considered outside the mainstream of scientific medicine as naturopathy or chiropractic and often involving nutritional measures.

(30) "Home CCO" means enrollment in a CCO in a given service area based upon a client's most recent permanent residency, determined at the time of original eligibility determination or most current point of CCO enrollment prior to hospitalization.

(31) "Intensive Case Management (ICM)" means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled who have complex medical needs including:

(a) Early identification of members eligible for ICM services;

(b) Assistance to ensure timely access to providers and capitated services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of capitated services and discharge planning; and

(e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

(32) "Licensed Health Entity" means a CCO that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.

(33) "Line Items" means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.

(34) "Managed care entity (MCE)" means, as stated in 42 CFR 457.10, an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers.

(35) "Marketing" means any communication from a PHP or a CCO to a potential member who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.

(36) "Medical Case Management Services" means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.

(37) "Member" has the meaning given that term in OAR 410-120-0000.

(38) "Mental Health Organization (MHO)" means a PHP that provides capitated behavioral services for clients.

(39) "National Association of Insurance Commissioners (NAIC)" means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

(40) "Net Premium" means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.

(41) "Non-Participating Provider" means a provider that does not have a contractual relationship with a PHP or CCO and is not on their panel of providers.

(42) "Oregon Health Authority or Authority Reporting CCO" means a CCO that reports its solvency plan and financial status to the Authority under these rules.

(43) "Other Non-Medical Services" means non-state plan, health related services, also referred to as "flexible services." These services are provided in–lieu of traditional benefits and are intended to improve care delivery, member health, and lower costs. Services may effectively treat or prevent physical or behavioral healthcare conditions. Services are consistent with the member's treatment plan as developed by the member's primary care team and documented in the member's medical record.

(44) "Participating Provider" means a provider that has a contractual relationship with a PHP or CCO and is on their panel of providers.

(45) "Physician Care Organization (PCO)" means a PHP that contracts with the Authority to provide partially-capitated health services under OHP exclusive of inpatient hospital services.

(46) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP or CCO.

(47) "Prioritized List of Health Services" means the listing of condition and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP health services.

(48) "Service Area" means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.

(49) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the healthcare professional. This therapeutic strategy is designed in collaboration with the member, the member's family, or the member representative and may incorporate patient education, dietary adjustment, an exercise program, drug therapy, and the participation of nursing and allied health professionals.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000. f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 45-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 16-2010, f. 6-11-10, cert. ef. 7-1-10; DMAP 42-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 11-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 45-2014, f. 7-15-14, cert. ef. 8-1-14; DMAP 54-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 71-2015, f. & cert. ef. 12-10-15; DMAP 39-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Preferred Drug List Requirements
Adm. Order No.: DMAP 40-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-141-3070
Subject: The Division's rule requires CCOs to demonstrate that they are able to provide coordinated care service efficiently, effectively, and economically. This rule provides CCOs with the framework for the Preferred Drug List Requirements under the Oregon Health Plan in the managed care environment.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-3070
Preferred Drug List Requirements

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. CCOs shall pay for prescription drugs except:

(a) As otherwise provided, mental health drugs that are in Standard Therapeutic Class 7 (ataractics-tranquilizers) or Standard Therapeutic Class 11 (psychostimulants-antidepressants), (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal, and their generic equivalents and those drugs that the Authority specifically carved out from capitation according to sections (8) and (9) of this rule;

(c) Any applicable co-payments;

(d) For drugs covered under Medicare Part D when the client is fully dual eligible.

(2) CCOs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337. CCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list shall:

(a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) CCOs shall provide their participating providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include, but are not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(4) Preauthorization for prescription drugs marked for urgent review shall be reviewed within 24 hours. If an urgent preauthorization for a prescription drug cannot be completed within 24 hours, the CCO shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. All requests, including those not marked urgent, shall be reviewed and decision rendered within 72 hours of original receipt of the preauthorization request.

(5) CCOs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider if the approved prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded. Payment is governed by OAR 410-121-0150.

(7) CCOs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs that have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List.

(8) A CCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all of the following information:

(a) The drug name;

(b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and

(c) The reason that the Authority should consider this drug for carve out.

(9) If a CCO requests that a drug not be paid within the global budget, the Authority shall exclude the drug from the global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.

(10) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121). A CCO may not reimburse providers for carved-out drugs.

(11) CCOs shall submit quarterly utilization data within 60 days of the date of service as part of the CMS Medicaid Drug Rebate Program requirements pursuant to Section 2501 of the Affordable Care Act.

(12) CCOs are encouraged to provide payment only for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. CCOs may continue to have some flexibility in maintaining formularies of drugs regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.

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 21-2014(Temp), f. & cert. ef. 4-1-14 thru 9-28-14; DMAP 32-2014, f. 5-30-14, cert. ef. 7-1-14; DMAP 40-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Managed Care Entity (MCE) Billing and Payment
Adm. Order No.: DMAP 41-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-141-3420
Rules Repealed: 410-141-0420
Subject: The Division's rule requires Managed Care Entities (MCEs) to demonstrate that they are able to provide coordinated care services efficiently, effectively, and economically. This is the first OHP managed care rule to consolidate the MCE requirements for billing and payment into one administrative rule. This is also the first OHP managed care rule to utilize the term Managed Care Entities (MCE) when making collective reference to those managed care plans providing the delivery system under the Oregon Health Plan. The Division proposes "Managed care entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers. Revisions to language have been made in the following areas:

- Clarifying the four-month billing requirement;
- Specifying separate plan type requirements as applicable;
- Aligning the pharmacy preauthorization timeline with 410-141-3070 Preferred Drug List Requirements;
- Updating claim submission timeframes with CFR and the 2016 contracts;
- Clarifying school-based health service considerations; and
- Updating A and B Hospital payment methodology language in order to align with current practices.

Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-3420
Managed Care Entity (MCE) Billing and Payment

(1) Providers shall submit all billings for MCE members in the following timeframes:

(a) Submit bills within no greater than four months of the date of service for all cases, except as provided for in (1) (b) of this rule. MCEs may negotiate terms within this timeframe agreeable to both parties;

(b) Submit billings within 12 months of the date of service in the following cases:

(A) Pregnancy;

(B) Eligibility issues such as retroactive deletions or retroactive enrollments;

(C) Medicare is the primary payer, except where the MCE is responsible for the Medicare reimbursement;

(D) Other cases that could have delayed the initial billing to the MCE not including failure of the provider to verify the member's eligibility; or

(E) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, 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 payers of last resort and are not considered an alternative liability or TPL.

(2) Providers shall be enrolled with the Division to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), shall be approved by the Local Mental Health Authority (LMHA) and the Division before enrollment with the Authority or to be eligible for MCE payment for services. FFS providers may be retroactively enrolled in accordance with OAR 410-120-1260 Provider Enrollment.

(3) Providers, including mental health providers, shall be enrolled with the Authority as a Medicaid FFS provider or an MCE encounter-only provider prior to submission of encounter claims to ensure the encounter claim is accepted.

(4) Providers shall verify before providing services that the client is:

(a) Eligible for Division programs and;

(b) Whether the client is assigned to an MCE on the date of service.

(5) Providers shall use the Authority's tools and the MCE's tools, as applicable, to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek prior authorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete an OHP 3165, or facsimile, signed by the client, as described in OAR 141-120-1280.

(6) MCEs shall pay for all covered capitated and coordinated care services. These services shall be billed directly to the MCE, unless the MCE or the Authority specifies otherwise. MCEs may require providers to obtain prior authorization to deliver certain capitated or coordinated care services.

(7) Payment by the MCE to participating providers for capitated or coordinated care services is a matter between the MCE and the participating provider except as follows:

(a) MCEs shall have written policies and procedures for processing prior authorization requests received from any provider and written policies and procedures for processing claims submitted from any source. The policies and procedures shall specify time frames for:

(A) Date stamping prior authorization requests and claims when received;

(B) Determining within a specific number of days from receipt whether a prior authorization request or a claim is valid or non-valid;

(C) The specific number of days allowed for follow-up on pended prior authorization requests or pended claims to obtain additional information;

(D) The specific number of days following receipt of the additional information that an approval or denial shall be issued;

(E) Providing services after office hours and on weekends that require prior authorization;

(F) Sending written 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) MCEs shall make a determination on at least 95 percent of valid prior authorization requests within two working days of receipt of a prior authorization or reauthorization request related to urgent services, alcohol and drug services, or care required while in a skilled nursing facility;

(c) Prior authorization for prescription drugs marked for urgent review shall be reviewed within 24 hours. If an urgent prior authorization for a prescription drug cannot be completed within 24 hours, the MCE shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. All pharmacy requests, including those not marked urgent, shall be reviewed and a decision rendered within 72 hours of original receipt of the prior authorization request;

(d) For expedited prior authorization requests in which the provider indicates or the MCE 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 MCE shall 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 MCE may extend the three working day time period no more than 14 calendar days if the member requests an extension or if the MCE justifies to the Authority a need for additional information and how the extension is in the member's best interest.

(e) For all other prior authorization requests, MCEs shall notify providers of an approval, a denial, or the need for further information with-

in 14 calendar days of receipt of the request as outlined in OAR 410-141-3263. MCEs shall make reasonable efforts to obtain the necessary information during the 14-day period. However, the MCE may use an additional 14 days to obtain follow-up information if the MCE justifies to the Authority, upon request, the need for additional information and how the delay is in the member's best interest. If the MCE extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in 410-141-3263. The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension;

(f) MCEs shall pay or deny at least 90 percent of valid claims within 30 calendar days of receipt and at least 99 percent of valid claims within 90 calendar days of receipt. MCEs shall make an initial determination on 99 percent of all claims submitted within 60 calendar days of receipt;

(g) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3263;

(h) MCEs may not require providers to delay billing to the MCE;

(i) MCEs 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) MCEs 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) MCEs may not delay or deny payments because a co-payment was not collected at the time of service;

(L) MCEs may not delay or deny payments for occupational therapy, physical therapy, speech therapy, nurse services, etc., when a child is receiving such services as school-based health services (SBHS) through either an Individual Educational Plan (IEP) or an Individualized Family Service Plan (IFSP). These services are supplemental to other health plan covered therapy services and are not considered duplicative services. Individuals with Disabilities Education Act (IDEA) mandated school sponsored SBHS will not apply toward the member's therapy allowances. SBHS Medicaid covered IDEA services are provided to eligible children in their education program settings by public education enrolled providers billing MMIS for these services to Medicaid through the Authority for reimbursement under Federal Financial Participation (FFP) as part of cost sharing on a fee-for-service basis.

(8) MCEs shall pay for Medicare coinsurances and deductibles up to the Medicare or MCE's allowable for covered services the member receives within the MCE participating provider network for authorized referral care and urgent care services or emergency services the member receives from non-participating providers. MCEs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(9) MCEs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the MCE has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(10) MCEs shall pay for ancillary, as defined in 410-120-0000, covered services provided by a non-participating provider that are not prior authorized if all of the following conditions exist:

(a) It can be verified that a participating provider ordered or directed the covered services to be delivered by a non-participating provider; and

(b) The ancillary covered service was delivered in good faith without the prior authorization; and

(c) It was an ancillary covered service that would have been prior authorized with a participating provider if the MCE's referral procedures had been followed;

(d) The MCE shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the MCE) for ancillary covered services that are subject to reimbursement from the MCE in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727;

(e) Except as specified in OAR 410-141-3140 Emergency and Urgent Care Services, MCEs shall not be required to pay for covered treatment services provided by a non-participating provider, unless:

(A) The MCE does not have a participating provider that will meet the member's medical need; and

(B) The MCE has authorized care to a non-participating provider.

(f) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;

(g) MCEs 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 that 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. MCEs shall attest annually to the Authority in a manner to be prescribed to MCE's compliance with these requirements.

(11) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) Sections (11)–(13) only apply to services provided by Type A or Type B hospitals to members that are enrolled in an MCE;

(b) In accordance with ORS 414.653, the Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require MCEs to continue to reimburse fully a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio;

(c) For those Type A or Type B hospitals that transitioned from CBR to an APM, the Authority shall require hospitals and MCEs to enter into good faith negotiations for contracts. Dispute resolution during the contracting process shall be subject to OAR 410-141-3268 and 410-141-3269, as applicable;

(d) For monitoring purposes, MCEs shall submit to the Authority no later than November 30 of each year a list of those hospitals with which they have contracted for these purposes.

(12) Determination of which Type A or Type B hospitals shall stay on CBR or transition from CBR:

(a) No later than June 30 of the odd numbered years, the Authority shall update the algorithm for calculation of the CBR determination methodology with the most recent data available;

(b) After determination for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1 of the following (even numbered) year;

(c) Type A and Type B hospitals located in a county that is designated as "Frontier" will not be subject to determination via the algorithm and shall remain on CBR.

(13) Non-contracted Type A or Type B hospital rates for those transitioning or transitioned from CBR:

(a) Reimbursement rates under this section shall be based on discounted hospital charges for both inpatient and outpatient services;

(b) Reimbursement rates effective for the initial calendar year of a hospital transitioning from CBR shall be based on that hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

(c) Subsequent year reimbursement rates for hospitals transitioned from CBR shall be calculated by the Authority based on the individual hospital's annual price increase and the Authority's global budget rate increase as defined by the CMS 1115 waiver using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(d) On an annual basis, each Type A or Type B hospital that has transitioned from CBR shall complete a template provided by the Authority that calculates the hospital's change in prices for their MCE population;

(e) Inpatient and outpatient reimbursement rates shall be calculated separately;

(f) Non-contracted Type A or Type B hospital reimbursement rates can be found in the Rate Table section at the following: http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx.

(14) Members may receive certain services on a Fee-for-Service (FFS) basis:

(a) Certain services shall be authorized by the MCE 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 shall verify a member's eligibility and MCE assignment as provided for in this rule;

(b) Services authorized by the MCE or CMHP are subject to the Authority's 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 Authority's administrative rules, contracts, and billing instructions;

(e) The Authority may not pay a provider for providing services for which an MCE has received an MCE 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 an MCE except as provided in Authority administrative rules and supplemental information (e.g., coordinated care and capitated services that are not included in the nursing facility all-inclusive rate);

(g) CCOs and MHOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the CCO and MHOs 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).

(15) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-0500 Excluded Services and Limitations for OHP Clients.

Stat. Auth.: ORS 413.042, 414.065, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.065 & 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; DMAP 60-2013, f. & cert. ef. 10-31-13; DMAP 65-2013, f. & cert. ef. 11-29-13; DMAP 34-2014(Temp), f. 6-25-14, cert. ef. 7-1-14 thru 12-27-14; DMAP 66-2014(Temp), f. 11-13-14, cert. ef. 12-28-14 thru 6-25-15; DMAP 71-2014, f. 12-8-14, cert. ef. 1-1-15; DMAP 41-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Requirements for CCO Appeal
Adm. Order No.: DMAP 42-2016
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Amended: 410-141-3262
Subject: This rule pertains to the Grievance System rules as required by 42 CR 438.420. This rule is the framework and guidance for the CCOs with which to administer the appeals process as required in CFR within the managed care delivery system. Revision of this rule provides clarification in the language for a standard appeal. An oral appeal request must be followed up by a written request. We have also provided clarification language regarding what happens should a member fail to follow up a standard oral request for an appeal with a written request.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-3262
Requirements for CCO Appeal

(1) A member, their representative, or a subcontractor/provider with the member's consent, who disagrees with a notice of action (notice), has the authority to file an appeal with their CCO.

(2) For purposes of this rule, an appeal includes a request from the Division to the CCO for review of action.

(3) The member may request an appeal either orally or in writing directly to their CCO for any action by the CCO. Unless the member requests an expedited resolution, the member must follow an oral filing with a written, signed, and dated appeal.

(4) The member must file the appeal no later than 45 calendar days from the date on the notice.

(5) If after filing an oral appeal, a member does not submit a written appeal request within the appeals timeframe, the appeal will expire.

(6) The CCO does not need to notify the member if the CCO has already made attempts to assist the member in filling out the necessary forms to file a written appeal as required by rule.

(7) The CCO shall have written policies and procedures for handling appeals that:

(a) Address how the CCO will accept, process, and respond to such appeals, including how the CCO will acknowledge receipt of each appeal;

(b) Ensure that members who receive a notice are informed of their right to file an appeal and how to do so;

(c) Ensure that each appeal is transmitted timely to staff having authority to act on it;

(d) Consistent with confidentiality requirements, ensure that the CCO's staff person who is designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt of the appeal;

(e) Ensure that each appeal is investigated and resolved in accordance with these rules; and

(f) Ensure that the individuals who make decisions on appeals are:

(A) Not involved in any previous level of review or decision making; and

(B) Health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if an appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues.

(g) Include a provision that the CCO must document appeals in an appeals log maintained by the CCO that complies with OAR 410-141-3260 and consistent with contractual requirements;

(h) Ensure oral requests for appeal of an action are treated as appeals to establish the earliest possible filing date for the appeal; and

(i) Ensure the member is informed that they must file in writing unless the person filing the appeal requests expedited resolution;

(j) Provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;

(k) Provide the member an opportunity before and during the appeals process to examine the member's file, including medical records and any other documents or records to be considered during the appeals process.

(8) Parties to the appeal include:

(a) The CCO;

(b) The member and the member's representative, if applicable;

(c) The legal representative of a deceased member's estate.

(9) The CCO shall resolve each appeal and provide the member and their representative with a notice of appeal resolution as expeditiously as the member's health condition requires and within the following periods for:

(a) Standard resolution of appeal: No later than 16 calendar days from the day the CCO receives the appeal;

(b) Expedited resolution of appeal (when granted by the CCO): No later than three working days from the date the CCO receives the appeal. In addition, the CCO must:

(A) Inform the member and their representative of the limited time available;

(B) Make reasonable efforts to call the member to tell them of the resolution within three calendar days after receiving the request; and

(C) Mail written confirmation of the resolution to the member within three calendar days.

(c) In accordance with 42 CFR 438.408, the CCO may extend these timeframes from subsections (a) or (b) of this section up to 14 calendar days if:

(A) The member or their representative requests the extension; or

(B) The CCO shows (to the satisfaction of the Division's Hearing Unit, upon its request) that there is need for additional information and how the delay is in the member's interest;

(C) If the CCO extends the timeframes, it must for any extension not requested by the member, give the member or their representative written notice of the reason for the delay.

(10) For all appeals, the CCO must provide written notice of appeal resolution to the member and also to their representative when the CCO knows there is a representative for the member.

(11) The written notice of appeal resolution must include the following information:

(a) The results of the resolution process and the date the CCO completed the resolution; and

(b) For appeals not resolved wholly in favor of the member:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;

(B) Unless the appeal was referred to the CCO from the Division as part of a contested case hearings process, the right to request a hearing and how to do so;

(C) The right to request to receive benefits while the hearing is pending and how to do so; and

(D) That the member may be held liable for the cost of those benefits if the hearing decision upholds the CCO's Action.

(12) Unless the appeal was referred to the CCO as part of a contested case hearing process, a member may request a hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution.

(13) If the appeal was referred to the CCO from the Division as part of a contested case hearing process within two business days from the date of the appeal resolution, the CCO must transmit the:

(a) Notice of Appeal Resolution; and

(b) Complete record of the appeal to the Division's Hearings Unit.

(14) If the appeal was made directly by the member or their representative, and the Notice of Appeal Resolution was not favorable to the member, the CCO must, if a contested case hearing is requested, submit the record to the Division's Hearings Unit within two business days of the Division's request.

(15) Documentation:

(a) The CCO's records must include, at a minimum, a log of all appeals received by the CCO and contain the following information:

(A) Member's name and Medical Care ID number;

(B) Date of the Notice;

(C) Date and nature of the appeal;

(D) Whether continuing benefits were requested and provided; and

(E) Resolution and resolution date of the appeal.

(b) The CCO shall maintain a complete record for each appeal included in the log for no less than 45 days to include:

(A) Records of the review or investigation; and

(B) Resolution, including all written decisions and copies of correspondence with the member.

(c) The CCO shall review the written appeals log on a monthly basis for:

(A) Completeness;

(B) Accuracy;

(C) Timeliness of documentation;

(D) Compliance with written procedures for receipt, disposition, and documentation of appeals; and

(E) Compliance with OHP rules.

(d) The CCO shall address the analysis of appeals in the context of quality improvement activity consistent with OAR 410-141-3200 — Outcome and Quality Measures and 410-141-3260 — Grievance System: Grievances, Appeals and Contested Case Hearings;

(e) The CCO shall have written policies and procedures for the review and analysis of all appeals received by the CCO. The analysis of the grievance system must be reviewed by the CCO's Quality Improvement Committee consistent with contractual requirements and comply with the quality improvement standards.

Stat. Auth.: ORS 413.032

Stats. Implemented: ORS 414.065

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 10-2013(Temp), f. & cert. ef. 3-1-13 thru 8-27-13; DMAP 16-2013(Temp), f. & cert. ef. 4-10-13 thru 8-27-13; DMAP 46-2013, f. & cert. ef. 8-26-13; DMAP 42-2016, f. & cert. ef. 7-1-16

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Rule Caption: Amending PDL March 31, 2016 DUR/P&T Action
Adm. Order No.: DMAP 43-2016(Temp)
Filed with Sec. of State: 7-1-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 410-121-0030
Subject: The Pharmaceutical Services Program administrative rules (Division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

410-121-0030:

Preferred:

Epoprostenol

Narcan® Nasal

Injectable Naloxone

Non-Preferred:

Calcium

Vitamin D

Evzio®

Auto Injector Naloxone

Clerical — Various clerical changes were made to system class, drug and form names.

Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-121-0030

Practitioner-Managed Prescription Drug Plan

(1) The Practitioner-Managed Prescription Drug Plan (PMPDP) is a plan that ensures that OHP fee-for-service clients have access to the most effective prescription drugs appropriate for their clinical conditions at the best possible price:

(a) Licensed health care practitioners who are informed by the latest peer reviewed research make decisions concerning the clinical effectiveness of the prescription drugs;

(b) Licensed health care practitioners also consider the client's health condition, personal characteristics, and the client's gender, race, or ethnicity.

(2) PMPDP Preferred Drug List (PDL):

(a) The PDL is the primary tool the Division uses to inform licensed health care practitioners about the results of the latest peer-reviewed research and cost effectiveness of prescription drugs;

(b) The PDL contains a list of prescription drugs that the Division, in consultation with the Drug Use Review (DUR)/Pharmacy & Therapeutics Committee (P&T), has determined represent the most effective drugs available at the best possible price;

(c) The PDL shall include drugs that are Medicaid reimbursable and the Food and Drug Administration (FDA) has determined to be safe and effective.

(3) PMPDP PDL Selection Process:

(a) The Division shall utilize the recommendations made by the P&T that result from an evidence-based evaluation process as the basis for selecting the most effective drugs;

(b) The Division shall ensure the drugs selected in section (3)(a) that are available for the best possible price and shall consider any input from the P&T about other FDA-approved drugs in the same class that are available for a lesser relative price. The Division shall determine relative price using the methodology described in section (4);

(c) The Division shall evaluate selected drugs for the drug classes periodically:

(A) The Division may evaluate more frequently if new safety information or the release of new drugs in a class or other information makes an evaluation advisable;

(B) New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T;

(C) The Division shall make all revisions to the PDL using the rule-making process and shall publish the changes on the Division's Pharmaceutical Services provider rules website.

(4) Relative cost and best possible price determination:

(a) The Division shall determine the relative cost of all drugs in each selected class that are Medicaid reimbursable and that the FDA has determined to be safe and effective;

(b) The Division may also consider dosing issues, patterns of use, and compliance issues. The Division shall weigh these factors with any advice provided by the P&T in reaching a final decision.

(5) Pharmacy providers shall dispense prescriptions in the generic form unless:

(a) The practitioner requests otherwise pursuant to OAR 410-121-0155;

(b) The Division notifies the pharmacy that the cost of the brand name particular drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug.

(6) The exception process for obtaining non-preferred physical health drugs that are not on the PDL drugs shall be as follows:

(a) If the prescribing practitioner in their professional judgment wishes to prescribe a physical health drug not on the PDL, they may request an exception subject to the requirements of OAR 410-121-0040;

(b) The prescribing practitioner must request an exception for physical health drugs not listed in the PDL subject to the requirements of OAR 410-121-0060;

(c) Exceptions shall be granted when:

(A) The prescriber in their professional judgment determines the non-preferred drug is medically appropriate after consulting with the Division or the Oregon Pharmacy Call Center; or

(B) Where the prescriber requests an exception subject to the requirement of section (6)(b) and fails to receive a report of PA status within 24 hours, subject to OAR 410-121-0060.

(7) Table 121-0030-1, PMPDP PDL dated May 1, 2016, is adopted and incorporated by reference and is found at: www.orpdl.org.

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

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.325, 414.330 to 414.414, 414.312 & 414.316

Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369, 414.371, 414.353 & 414.354

Hist.: OMAP 25-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 31-2002, f. & cert. ef. 8-1-02; OMAP 36-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 35-2003, f. & cert. ef. 5-1-03; OMAP 47-2003, f. & cert. ef. 7-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 70-2003(Temp), f. 9-15-03, cert. ef. 10-1-03 thru 3-15-04;

OMAP 82-2003, f. 10-31-03, cert. ef. 11-1-03; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 29-2004, f. 4-23-04 cert. ef. 5-1-04; OMAP 34-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 45-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 81-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 32-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 58-2005, f. 10-27-05, cert. ef. 11-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 48-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 2-2011(Temp), f. & cert. ef. 3-1-11 thru 8-20-11; DMAP 19-2011, f. 7-15-11, cert. ef. 7-17-11; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 18-2012, f. 3-30-12, cert. ef. 4-9-12; DMAP 26-2012, f. & cert. ef. 5-14-12; DMAP 29-2012, f. & cert. ef. 6-21-12; DMAP 33-2012(Temp), f. 7-18-12, cert. ef. 7-23-12 thru 1-18-13; DMAP 40-2012(Temp), f. & cert. ef. 8-20-12 thru 1-18-13; DMAP 44-2012(Temp), f. & cert. ef. 9-26-12 thru 1-18-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 6-2013(Temp), f. & cert. ef. 2-21-13 thru 8-19-13; DMAP 23-2013(Temp), f. 4-30-13, cert. ef. 5-1-13 thru 8-19-13; Administrative correction, 7-18-13; DMAP 43-2013, f. & cert. ef. 8-16-13; DMAP 76-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 1-2014(Temp), f. & cert. ef. 1-10-14 thru 7-9-14; DMAP 15-2014, f. & cert. ef. 3-21-14 thru 9-17-14; DMAP 28-2014(Temp), f. & cert. ef. 5-2-14 thru 6-30-14; DMAP 37-2014, f. & cert. ef. 6-30-14; DMAP 47-2014(Temp), f. & cert. ef. 7-15-14 thru 1-11-15; DMAP 52-2014(Temp), f. & cert. ef. 9-16-14 thru 1-11-15; DMAP 64-2014(Temp), f. 10-24-14, cert. ef. 10-29-14 thru 12-30-14; DMAP 77-2014, f. & cert. ef. 12-12-14; DMAP 78-2014(Temp), f. & cert. ef. 12-12-14 thru 6-9-15; DMAP 88-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 10-2015(Temp), f. & cert. ef. 3-3-15 thru 8-29-15; DMAP 26-2015(Temp), f. 4-17-15, cert. ef. 4-18-15 thru 6-26-15; DMAP 35-2015, f. 6-25-15, cert. ef. 6-26-15; DMAP 37-2015(Temp), f. & cert. ef. 7-1-15 thru 12-27-15; DMAP 57-2015(Temp), f. 9-30-15, cert. ef. 10-1-15 thru 12-27-15; DMAP 64-2015(Temp), f. & cert. ef. 11-3-15 thru 12-27-15; DMAP 66-2015(Temp), f. & cert. ef. 11-6-15 thru 12-27-15; DMAP 79-2015, f. 12-22-15, cert. ef. 12-27-15; DMAP 84-2015(Temp), f. 12-23-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 18-2016(Temp), f. 4-28-16, cert. ef. 5-1-16 thru 6-28-16; DMAP 27-2016, f. 6-24-16, cert. ef. 6-28-16; DMAP 43-2016(Temp), f. & cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Amending Rules to Comply with Amended CFR's, Gender Identity and Provider Enrollee Communications
Adm. Order No.: DMAP 44-2016(Temp)
Filed with Sec. of State: 7-6-2016
Certified to be Effective: 7-6-16 thru 1-1-17
Notice Publication Date:
Rules Amended: 410-141-3015, 410-141-3145, 410-141-3260, 410-141-3300
Subject: These temporary rules provide immediate direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans in order to be compliant with the newly revised Code of Federal Regulations that become effective within sixty days of publication, May 5, 2016. These rules need to be amended to reflect current federal changes related to provider enrollee communications requirements and the addition of gender identity to the certification criteria.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-3015
Certification Criteria for Coordinated Care Organizations

(1) Applicants shall submit applications to the Authority describing their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall use the RFA procurement process described in OAR 410-141-3010.

(2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO certification within the context of the Oregon Health Policy Board's report, Coordinated Care Organizations Implementation Proposal: HB 3650 Health System Transformation (Jan. 24, 2012).

(3) Applicants shall describe their demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

(A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above $250,000;

(B) Maintaining a net worth in an amount equal to at least 5 percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget;

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;

(e) Coordinating the delivery of physical health care, mental health and Substance Use Disorder (SUD) services, oral health care, and covered long-term care services;

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

(4) In selecting one or more CCOs to serve a geographic area, the Authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with CCOs; and

(c) Allow more than one CCO to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) Evaluation of CCO applications shall account for the developmental nature of the CCO system. The Authority recognizes that CCOs and partner organizations will need time to develop capacity, relationships, systems, and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System. The Authority shall thoroughly review how the application describes community involvement in the governance of the CCO and the CCO's strategic plan for developing its community health assessment and community health improvement plan:

(a) In all cases, CCOs shall have plans in place to meet the criteria laid out in these rules and the application process and to make sufficient progress in implementing plans and realizing the goals established in contract;

(b) Each criterion will be listed followed by the elements that shall be addressed during the initial certification described in this rule without limiting the information that is requested in the RFA concerning these criteria.

(6) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. The applicant shall:

(a) Clearly describe how it meets governance structure criteria from ORS 414.625, how the governance structure makeup reflects community needs and supports the goals of health care transformation, how the criteria is used to select governance structure members, and how it will assure transparency in governance;

(b) Identify key leaders who are responsible for successful implementation and sustainable operation of the CCO;

(c) Describe how its governance structure will reflect the needs of members with severe and persistent mental illnesses and members receiving DHS Medicaid-funded, long-term care services and supports.

(7) Each CCO shall convene a community advisory council (CAC) that meets the requirements of ORS 414.625. The applicant shall clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.625, how the CAC will be administered to achieve the goals of community involvement, and the development, adoption, and updating of the community health assessment and community health improvement plan.

(8) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office, and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:

(a) Since community health assessments will evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before becoming certified;

(b) The applicant shall describe how it will develop its health assessment, meaningfully and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community need that builds on community resources and skills and emphasizes innovation.

(9) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.

(10) Dental care organizations: On or before July 1, 2014, each CCO shall have a contractual relationship with any DCO in its service area.

(11) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed unless good cause can be shown:

(a) CCOs shall also have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;

(b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met unless good cause is shown why an agreement is not feasible.

(12) CCOs shall provide integrated, person-centered care and services designed to provide choice, independence, and dignity:

(a) The applicant shall describe its strategy to assure that each member receives integrated, person-centered care and services designed to provide choice, independence, and dignity;

(b) The applicant shall describe its strategy for providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.

(13) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall:

(a) Describe their planned or established policies and procedures that protect member rights including access to qualified peer wellness specialists, personal health navigators, and qualified community health workers where appropriate;

(b) Describe planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.

(14) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:

(a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;

(b) Ensure that member choices are reflected in the development of treatment plans, and member dignity is respected.

(15) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:

(a) Work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of all members;

(b) Are educated about the integrated approach and how to access and communicate within the integrated system about a member's treatment plan and health history;

(c) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making, and communication;

(d) Are permitted to participate in the networks of multiple CCOs;

(e) Include providers of specialty care;

(f) Are selected by the CCO using universal application and credentialing procedures, objective quality information, and are removed if the providers fail to meet objective quality standards.

(g) Describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and Substance Use Disorder (SUD) service providers, and dental care when the CCO includes a dental care organization and facilitate access to community social and support services including DHS Medicaid-funded long-term care services, mental health crisis services, and culturally and linguistically appropriate services;

(h) Describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.

(16) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.

(17) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patient-centered primary care homes and individualized care:

(a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans particularly for members with intensive care coordination needs, and screen for all other issues including mental health;

(b) Applicants shall describe how its implementation of individualized care plans reflects member or family and caregiver preferences and goals to ensure engagement and satisfaction.

(18) CCOs shall assure that members receive comprehensive transitional health care including appropriate follow-up care when entering or leaving an acute care facility or long-term care setting. Applicants shall:

(a) Describe their strategy for improved transitions in care so that members receive comprehensive transitional care, and members' experience of care and outcomes are improved;

(b) Demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes;

(c) Describe their arrangements, including memorandum of understanding, with Type B Area Agencies on Aging or the Department's offices of Aging and People with Disabilities concerning care coordination and transition strategies for members.

(19) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, community health workers, and personal health navigators. The applicant shall describe its planned policies for informing members about access to personal health navigators, peer wellness specialists where appropriate, and community health workers.

(20) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:

(a) Delivery system elements that respond to member needs for access to coordinated care services and supports;

(b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;

(c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long term psychiatric care settings.

(21) Each CCO shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with severe and persistent mental illness covered under the State's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:

(a) Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;

(b) Reflect member or family and caregiver preferences and goals to ensure engagement and satisfaction.

(22) Each CCO shall participate in the learning collaborative described in ORS 442.210. Applicants shall confirm their intent to participate.

(23) Each CCO shall implement to the maximum extent feasible patient-centered primary care homes including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations:

(a) The applicant shall describe its plan to develop and expand capacity to use patient-centered primary care homes to ensure that members receive integrated, person-centered care and services and that members are fully informed partners in transitioning to this model of care;

(b) The applicant shall require its other health and services providers to communicate and coordinate care with patient−centered primary care homes in a timely manner using health information technology.

(24) CCOs' health care services shall focus on achieving health equity and eliminating health disparities. Applicants shall:

(a) Describe their strategy for ensuring health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender identity, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;

(b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender identity, sexual orientation, geography, or other factors through community health assessment;

(c) Collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Division.

(25) CCOs are encouraged to use alternative payment methodologies consistent with ORS 414.653. The applicant shall describe its plan to move toward and begin to implement alternative payment methods alone or in

combination with delivery system changes to achieve better care, controlled costs, and better health for members.

(26) Each CCO shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe:

(a) Its initial and anticipated levels of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically and its HIT improvement plan for meeting transformation expectations;

(b) Its plan to ensure that each network provider participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.

(27) Each CCO shall report on outcome and quality measures identified by the Authority under ORS 414.638 and participate in the All Payer All Claims (APAC) data reporting system. The applicant shall provide assurances that:

(a) It has the capacity to report and demonstrate an acceptable level of performance with respect to Authority-identified metrics;

(b) It will submit APAC data in a timely manner according to program specifications.

(28) Each CCO shall be transparent in reporting progress and outcomes. Applicants shall:

(a) Describe how it will assure transparency in governance;

(b) Agree to provide timely access to certain financial, outcomes, quality, and efficiency metrics that will be transparent and publicly reported and available on the Internet.

(29) Each CCO shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:

(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.625;

(b) Whether the CCO will use a clinical advisory panel (CAP) or other means to ensure clinical best practices;

(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.

(30) Each CCO shall demonstrate sound fiscal practices and financial solvency and shall possess and maintain resources needed to meet their obligations:

(a) Initially, the financial applicant shall submit required financial information that allows the DCBS Insurance Division on behalf of the Authority to confirm financial solvency and assess fiscal soundness;

(b) The applicant shall provide information relating to assets and financial and risk management capabilities.

(31) Each CCO may provide coordinated care services within a global budget. Applicants shall submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.

(32) A CCO shall operate, administer, and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant shall provide assurances about compliance with requirements applicable to the administration of the medical assistance program.

(33) Each CCO shall provide covered Medicaid services, other than DHS Medicaid-funded long-term care services, to members who are dually eligible for Medicare and Medicaid. The applicant may participate in the CMS Medicare/Medicaid Alignment Demonstration if the Authority obtains necessary federal approvals.

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 45-2014, f. 7-15-14, cert. ef. 8-1-14; DMAP 44-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

410-141-3145
Community Health Assessment and Community Health Improvement Plans

(1) Pursuant to ORS 414.627 to the extent practicable, CCOs shall partner with their local public health authority, local mental health authority, and hospital systems to develop a shared Community Health Assessment (CHA) process including conducting the assessment and development of the resulting Community Health Improvement Plan (CHP).

(2) CCOs shall work with the Authority to identify the components of the CHA. CCOs are encouraged to partner with their local public health authority, hospital system, type B Area Agency on Aging, APD field office and local mental health authority, the Early Learning Council, the Youth Development Council, and school health providers in the region using existing resources when available and avoiding duplication where practicable.

(3) In developing and maintaining a health assessment, CCOs shall meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community health needs that build on community resources and skills and emphasizes innovation including, but not limited to, the following:

(a) Emphasis on disproportionate, unmet, health-related need;

(b) Emphasis on primary prevention;

(c) Building a seamless continuum of care;

(d) Building community capacity;

(e) Emphasis on collaborative governance of community benefit.

(4) The CCO requirements for conducting a CHA and CHP will be met for purposes of ORS 414.627 if they substantially meet the community health needs assessment requirement of the federal Patient Protection and Affordable Care Act, 2010 Section 9007, and the Public Health Accreditation Board CHA and CHP requirements for local health departments and the AAA and local mental health authority in the process.

(5) The CCO's CAC shall oversee the CHA and adopt a plan to serve as a strategic population health and health care system service plan for the community served by the CCO. The Council shall annually publish a report on the progress of the CHP.

(6) The CHP adopted by the Council shall describe the scope of the activities, services, and responsibilities that the CCO shall consider upon implementation. The activities, services, and responsibilities defined in the CHP may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities, and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery;

(f) Workforce development; and

(g) Public Health Accreditation Board standards for CHPs.

(7) CCOs and their participating providers shall work together to develop best practices of culturally and linguistically appropriate care and service delivery to eliminate health disparities and improve member health and well-being.

(8) CCOs and their CAC shall collaborate with the Authority's Office of Equity and Inclusion to develop meaningful baseline data on health disparities. CCOs shall include in the CHA identification and prioritization of health disparities among CCOs' diverse communities, including those defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, or other factors in their service areas such as type of living setting including, but not limited to, home independent support living, adult foster home, or homeless. CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority. CCOs shall also include representatives of populations experiencing health disparities in CHA and CHP prioritization. CCOs shall track and report on any quality measure by these demographic factors and shall develop, implement, and evaluate strategies to improve health equity among members. CCOs shall make this information available by posting on the web.

(9) To the extent practicable, CCOs shall:

(a) Base the CHP on research including research into adverse childhood experiences;

(b) Evaluate the adequacy of the existing school-based health center (SBHC) network to meet the specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC system;

(c) Improve the integration of all services provided to meet the needs of children, adolescents, and families;

(d) Address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents;

(e) With the development of its CHP SBHCs, school nurses, school mental health providers, and individuals representing child and adolescent health services shall be included.

(10) CCOs shall develop and review and update its CHA and plan at least every five years to ensure the provision of all medically appropriate

covered coordinated care services including urgent care and emergency services, preventive, community support, and ancillary services in those categories of services included in CCO contracts or agreements with the Authority.

(11) CCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(12) If there is more than one CCO in a community, the CCOs and their community partners may work together to develop one shared CHA and one shared CHP.

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 45-2014, f. 7-15-14, cert. ef. 8-1-14; DMAP 44-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

410-141-3260

Grievance System: Grievances, Appeals and Contested Case Hearings

(1) This rule applies to requirements related to the grievance system, which includes appeals, contested case hearings, and grievances. For purposes of this rule and OAR 410-141-3261 through 410-141-3264, references to member means a member, member's representative and the representative of a deceased member's estate.

(2) The CCO must establish and have a Division approved process and written procedures for the following:

(a) Member rights to appeal and request a CCO's review of an action;

(b) Member rights to request a contested case hearing on a CCO action under the Administrative Procedures Act; and

(c) Member rights to file a grievance for any matter other than an appeal or contested case hearing;

(d) An explanation of how CCOs shall accept, process and respond to appeals, hearing requests and grievances;

(e) Compliance with grievance system requirements as part of the state quality strategy and to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure consistent response to complaints of violations of consumer right and protections.

(3) Upon receipt of a grievance or appeal, the CCO must:

(a) Acknowledge receipt to the member;

(b) Give the grievance or appeal to staff with the authority to act upon the matter;

(c) Obtain documentation of all relevant facts concerning the issues;

(d) Ensure staff making decisions on the grievance or appeal are:

(A) Not involved in any previous level of review or decision-making; and

(B) Health care professionals as defined in OAR 410-120-0000 with appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves clinical issues or if the member requests an expedited review.

(4) The CCO must analyze all grievances, appeals and hearings in the context of quality improvement activity pursuant to OAR 410-141-3200 and 410-141-3260.

(5) CCOs must keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as the terms treatment, payment or CCO health care operations are defined in 45 CFR 164.501.

(6) The following pertains to release of a member's information:

(a) The CCO and any provider whose authorizations, treatments, services, items, quality of care or requests for payment are involved in the grievance, appeal or hearing may use this information without the member's signed release for purposes of:

(A) Resolving the matter; or

(B) Maintaining the grievance or appeals log.

(b) If the CCO needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the CCO must obtain the member's signed release and retain the release in the member's record.

(7) The CCO must provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals or hearing requests. Reasonable assistance includes, but is not limited to:

(a) Assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;

(b) Free interpreter services;

(c) Toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and

(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

(8) The CCO and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal or hearing process;

(b) Encourage the withdrawal of a grievance, appeal or hearing request already filed; or

(c) Use the filing or resolution of a grievance, appeal or hearing request as a reason to retaliate against a member or to request member disenrollment.

(9) In all CCO administrative offices and in those physical, behavioral and oral health offices where the CCO has delegated response to the appeal, hearing request or grievance, the CCO must have the following forms available:

(a) OHP Complaint Form (OHP 3001);

(b) Appeal forms;

(c) Hearing request form (DHS 443) and Notice of Hearing Rights (DMAP 3030); or

(d) The Division of Medical Assistance Programs Service Denial Appeal and Hearing Request form (DMAP 3302) or approved facsimile.

(10) A member's provider:

(a) Acting on behalf of and with written consent of the member may file an appeal;

(b) May not act as the member's authorized representative for requesting a hearing or filing a grievance.

(11) The CCO and its participating providers must cooperate with the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all activities related to member appeals, hearing requests and grievances including providing all requested written materials.

(12) If the CCO delegates the grievance and appeal process to a subcontractor, the CCO must:

(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3261 through 410-141-3264;

(b) Monitor the subcontractor's performance on an ongoing basis;

(c) Perform a formal compliance review at least once a year to assess performance, deficiencies or areas for improvement; and

(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

(13) CCO's must maintain yearly logs of all appeals and grievances for seven calendar years with the following requirements:

(a) The logs must contain the following information pertaining to each member's appeal or grievance:

(A) The member's name, ID number, and date the member filed the grievance or appeal;

(B) Documentation of the CCO's review, resolution or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;

(C) Notations of oral and written communications with the member; and

(D) Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this.

(b) For each calendar year, the logs must contain the following aggregate information:

(A) The number of actions; and

(B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.

(14) The CCO must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.

(15) A member or a member's provider may request an expedited resolution of an appeal or a contested case hearing if the member or provider believes taking the standard time of resolution could seriously jeopardize the member's:

(a) Life, health, mental health or dental health; or

(b) Ability to attain, maintain or regain maximum function.

(16) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:

(a) To be entitled to continuing benefits, the member must complete a hearing request or request for appeal requesting continuing benefits no later than:

(A) The tenth day following the date of the notice or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness under section (3)(a) of this rule, delay for good cause, as defined in OAR 137-002-0528, is not counted;

(c) The benefits must be continued until:

(A) A final appeal resolution resolves the appeal unless the member requests a hearing with continuing benefits no later than ten days following the date of the notice of appeal resolution;

(B) A final order resolves the contested case;

(C) The time period or service limits of a previously authorized service have been met; or

(D) The member withdraws the request for hearing.

(17) The CCO shall review and report to the Authority complaints that raise issues related to racial or ethnic background, gender identity, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.

(18) If a CCO receives a complaint or grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO for reasons defined in OAR 410-141-3080 (15) the CCO shall log the complaint/grievance and work with the receiving/sending CCO to ensure continuity of care during the transition.

Stat. Auth.: ORS 413.032, 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 54-2012(Temp), f. & cert. ef. 11-1-2 thru 4-29-13; DMAP 22-2013, f. & cert. ef. 4-26-13; DMAP 60-2013, f. & cert. ef. 10-31-13; DMAP 33-2014, f. 5-30-14, cert. ef. 7-1-14; DMAP 44-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

410-141-3300

Coordinated Care Organization (CCO) Member Education and Information Requirements

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

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide;

(b) "Alternate Format Statement Insert" means an insert developed by the Oregon Health Authority that includes instructions on how to receive an alternate format or oral interpretation of materials translated into the state's top sixteen preferred written languages as identified by OHP enrollees. CCOs shall insert their contact information into the template.

(c) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

(d) "Prevalent Non-English Language" means: All non-English languages that are identified as the preferred written language by the lesser of either:

(A) 5 percent of the CCO's total OHP enrollment; or

(B) 1, 000 of the CCO's members.

(2) CCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Division shall approve, prior to distribution, any written communication by the CCO or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.

(3) CCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes. The intent of these communications should be informational only and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. CCOs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(4) The creation of name recognition because of the CCO's health promotion or education activities shall not constitute an attempt by the CCO to influence a client's enrollment.

(5) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors shall not constitute an attempt to compel or entice a client's enrollment.

(6) The following shall not constitute marketing or an attempt by the CCO to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan;

(b) Improving coordination of care;

(c) Communicating with providers serving dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(7) CCOs shall have a mechanism to help members understand the requirements and benefits of the CCO's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate.

(8) CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. As a CCO transitions to fully coordinating a member's care, the CCO is responsible only for including information about the care they are coordinating. CCOs shall update their educational material as they add coordinated services. Member education shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators and include information to members that interpreter services at provider offices are free to CCO members as stated in 42 CFR 438.10 (4).

(9) Within 14 calendar days or a reasonable timeframe of a CCO's receiving notice of a member's enrollment, CCOs shall mail a welcome packet to new members and to members returning to the CCO twelve months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory

(10) Provider directories shall include notation of the following: names, locations, telephone numbers including TTY, office hours, accessibility for members with disabilities, non-English languages spoken by current contracted providers in the enrollee's service area, and direction on how members can access information on providers that are not accepting new patients.

(11) For those who are existing members, a CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. CCOs shall send hard copies upon request.

(12) CCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the CCO:

(A) Welcome Packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes.

(b) Alternate format statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Action to deny, reduce, or stop a benefit.

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the CCO;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages, not just prevalent non-English languages;

(e) Notify enrollees:

(A) That oral interpretation is available free of charge for any language, and written information is available in prevalent non-English languages and alternate formats; and

(B) How to access those services.

(f) Make available materials in alternate formats by request. Alternate formats include but are not limited to audio recording, close-captioned videos, large type, and braille.

(13) A CCO shall electronically provide to the Division for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to audio recordings, close-captioned videos, large (18 point) type, and braille.

(c) CCO's office location, mailing address, web address if applicable, office hours, and telephone numbers including TTY;

(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs and the CCO's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

(f) What participating or non-participating provider services the member may self-refer;

(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(h) Explanation of intensive care coordination services and how members with the following special health care needs can access intensive care coordination services: Those who are aged, blind, or disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, or chemical dependency.

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;

(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;

(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;

(L) Information on contracted hospitals in the member's service area;

(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;

(n) Information on the CCO's grievance and appeals processes and the Division's contested case hearing procedures, including:

(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3260;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3263.

(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;

(p) Information on copayments, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO for non-emergent care; including information specific to copayments, deductibles, and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;

(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;

(s) Information on advance directive policies including:

(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

(t) Whether or not the CCO uses provider incentives to reduce cost by limiting services;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee and that they may request the record be amended or corrected;

(v) How and when members are to obtain ambulance services;

(w) Resources for help with transportation to appointments with providers;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

(y) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(z) The CCO's confidentiality policy:

(aa) How and where members are to access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;

(bb) When and how members can voluntarily and involuntarily disenroll from CCOs and change CCOs;

(cc) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;

(dd) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and a CCO may not use it to substitute for any component of the CCO's member handbook.

(14) Member health education shall include:

(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. CCO providers or other individuals or programs approved by the CCO may provide health education. CCOs shall endeavor to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) Information specifying that CCOs may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

(A) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(B) Any information the enrollee needs to decide among all relevant treatment options;

(C) The risks, benefits, and consequences of treatment or non-treatment.

(c) CCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Division may assist in developing materials that address specifically identified health education problems to the population in need;

(d) Explanation of intensive care coordination services and how to access intensive care coordination through outreach to members with special health care needs who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, or chemical dependency;

(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(f) CCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from CCO's participating providers. The CCO shall provide, translated as appropriate, the notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the CCO sufficient notification to meet the 30-day notice requirement. The Division shall review and approve the materials within two working days.

(15) Informational materials that CCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English:

(a) CCOs shall provide free interpreters for all of their members with hearing impairments and limited English proficiency who request them. This also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care:

(A) CCOs shall translate materials into all languages as identified in this rule. Written and spoken language preferences are indicated on the OHP application form and reported to plans in 834 enrollment updates. CCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(B) CCOs shall provide written translations of informational materials including their welcome packet, consisting of at least a welcome letter

and a member handbook in all languages as specified in this rule and as identified by members either through the OHP application or other means as their preferred written language.

(b) Form correspondence may be sent to members, including, but not limited to, enrollment information and notices of action to deny or stop a benefit, accompanied by alternate format statement inserts as specified in section (12) of this rule. If sent in English to members who prefer a different language, the tag lines, placed in the alternate format statement insert shall have instructions on how to receive an oral or written translation of the material.

(16) CCOs shall provide an identification card to members, unless waived by the Division, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the CCO, members, and providers.

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 16-2015, f. 3-31-15, cert. ef. 4-1-15; DMAP 21-2015, f. 4-14-15, cert. ef. 4-15-15; DMAP 24-2015, f. & cert. ef. 4-15-15; DMAP 44-2016(Temp), f. & cert. ef. 7-6-16 thru 1-1-17

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Rule Caption: Update Reference to Current Covered and Non-Covered Dental Services Document, Incorporate Changes and Corrections
Adm. Order No.: DMAP 45-2016
Filed with Sec. of State: 7-13-2016
Certified to be Effective: 7-13-16
Notice Publication Date: 6-1-2016
Rules Amended: 410-123-1260
Subject: The amendment of OAR 410-123-1260 is needed to align the administrative rule to reflect recent changes to the Prioritized List of Health Services and the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature (CDT Codes). Effective January 1, 2016, the Health Evidence Review Commission (HERC) added five oral health procedure codes to funded lines of the Prioritized List of Health Services. Four of these codes are either diagnostic or are payable dependent on other codes. The HERC also added a guideline to one of the codes, which this amendment reflects. In addition, the ADA deleted five CDT Codes that were on the prioritized list. Those changes are reflected in this amendment. The Authority needs to spell out in rule how the Oregon Health Plan will cover a newly opened CDT code. This will allow dentists to bill for two yearly applications of silver diamine fluoride, and the rule outlines exceptions.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-123-1260
OHP Dental Benefits

This administrative rule aligns with and reflects changes to the Prioritized List of Health Services and the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature (CDT Codes), as well as a restoration of benefits resulting from legislative action in 2015. Effective January 1, 2016, the Health Evidence Review Commission (HERC) added and deleted oral health procedure codes. This rule provides information on how the Oregon Health Plan will cover newly opened CDT codes and restored benefits as of July 1, 2016.

(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 include, but are not limited to:

(i) Dental screening services for eligible EPSDT individuals; and

(ii) Dental diagnosis and treatment that 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 shall 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's Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at www.oregon.gov/oha/healthplan/Pages/dental.aspx.

(b) Restorative, periodontal, and prosthetic treatments:

(A) Documentation shall be included in the client's charts to support the treatment. Treatments shall be consistent with the prevailing standard of care 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) ENHANCED ORAL HEALTH SERVICES IN PRIMARY CARE SETTINGS:

(a) Topical fluoride treatment:

(A) For children under 19 years of age, topical fluoride varnish may be applied by a licensed medical practitioner during a medical visit. Providers must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with either the appropriate Current Dental Terminology (CDT) code (D1206-Topical Fluoride Varnish) or the appropriate Current Procedural Terminology (CPT) code (99188 – Application of topical fluoride varnish by a physician or other qualified health care professional).

(B) Topical fluoride treatment from a medical practitioner counts toward the overall maximum number of fluoride treatments, as described in subsection (4) of this rule.

(b) Assessment of a patient:

(A) For children under six years of age, CDT code D0191-Assessment of a Patient is covered as an enhanced oral health service in medical settings;

(B) For reimbursement in a medical setting, D0191-Assessment of a patient must include all of the following components:

(i) Caries risk assessment using a standardized tool endorsed by Oregon Oral Health Coalition, the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics;

(ii) Anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;

(iii) Referral to a dentist in order to establish a dental home;

(iv) Documentation in medical chart of risk assessment findings and service components provided.

(C) For reimbursement, the performing provider must meet all of the following criteria:

(i) Be a physician (MD or DO), an advance practice nurse, or a licensed physician assistant; and

(ii) Hold a certificate of completion from one of the following approved training programs within the previous three years:

(I) Smiles for Life; or

(II) First Tooth through the Oregon Oral Health Coalition.

(D) For reimbursement, the medical practitioners must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with the appropriate CDT code (D0191-Assessment of a Patient).

(E) D0191 Assessment of a Patient may be reimbursed under this subsection up to a maximum of once every 12 months;

(F) D0191 Assessment of a Patient from a medical practitioner does not count toward the maximum number of CDT code D0191-Assessment of a Patient services performed by a dental practitioner described in subsection three (3) of this rule.

(c) For tobacco cessation services provided during a medical visit, follow criteria outlined in OAR 410-130-0190.

(3) DIAGNOSTIC SERVICES:

(a) Exams:

(A) For children under 19 years of age:

(i) The Division shall reimburse exams (billed as CDT codes 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 CDT codes 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 must not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams performed 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 performed by a dental hygienist (with or without an expanded practice permit).

(b) Assessment 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. Assessment of a patient (D0191) is included as part of an exam (D0120-D0180);

(iv) For children under 19 years of age, a maximum of twice every 12 months; and

(v) For adults age 19 and older, a maximum of once every 12 months.

(B) 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 shall 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 ten periapicals and two bitewings for a total of 12 films;

(ii) For clients ages 12 and older — a minimum of ten 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 is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records shall be included in the client's records;

(K) Digital radiographs, if printed, shall be on photo paper to assure sufficient quality of images.

(4) 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 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) Additional topical fluoride treatments may be available, up to a total of four treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for 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 years 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.

(D) Fluoride 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 ten services within a three-month period.

(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.

(f) Interim caries arresting medicament application (D1354):

(A) Is limited to silver diamine fluoride (SDF) application as the medicament. It does not include coverage of any other medicaments;

(B) May be billed for two applications per year;

(C) Requires that the tooth or teeth numbers be included on the claim;

(D) Shall be covered with topical application of fluoride (D1206 or D1208) when they are performed on the same date of service if D1354 is being used to treat a carious lesion and D1206 or D1208 to prevent caries;

(E) Shall be covered with an interim therapeutic restoration (D2941) or a permanent restoration and (D1354) on the same tooth, when dentally appropriate.

(5) RESTORATIVE SERVICES:

(a) Amalgam and resin-based composite restorations, direct:

(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;

(B) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;

(C) 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 shall 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) Interim therapeutic restoration on primary dentition (D2941) is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration;

(H) Reattachment of tooth fragment (D2921) is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;

(I) The Division reimburses for a surface not more than once in each treatment episode regardless of the number or combination of restorations;

(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.

(b) Indirect 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 percent of the tooth structure must be remaining for coverage of the core buildup.

(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) Stainless steel crowns (D2930/D2931) are allowed only for anterior primary teeth and posterior permanent or primary 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) are allowed only for anterior teeth, permanent or primary;

(ii) Prefabricated stainless steel crowns with resin window (D2933) are allowed only for anterior teeth, permanent or primary;

(iii) Prefabricated post and core in addition to crowns (D2954/D2957);

(iv) 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.

(v) PFM crowns (D2751 and D2752) shall 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 410-123-1100 Services Reviewed by the Division);

(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 millimeters and over, documentation shall 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 the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture shall 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.

(6) ENDODONTIC SERVICES:

(a) 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.

(b) Endodontic retreatment and apicoectomy:

(A) The Division does not cover retreatment of a previous root canal or apicoectomy 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.

(c) 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;

(d) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;

(e) Apexification/recalcification procedures:

(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;

(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant.

(7) 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 gingivoplasty 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) Allowed once every two years;

(ii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;

(iii) 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.

(iv) 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) allowed only once every two years.

(c) Periodontal maintenance (D4910) allowed once every six months:

(A) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;

(B) 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 increased periodontal maintenance (chart notes, pocket depths and radiographs).

(d) Records shall 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).

(8) 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) 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 shall 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 shall 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 mastication. Third molars are not a consideration when counting missing teeth;

(D) The dental practitioner shall 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 of age, the Division shall replace:

(i) Full dentures once every ten years, only if dentally appropriate;

(ii) Partial dentures once every five years, only if dentally appropriate.

(B) The five- and 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 the 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 or CCO. The client would not be eligible for another partial until February 3, 2022, regardless of DCO, CCO, or FFS enrollment;

(C) Replacement of partial dentures with full dentures is payable five 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 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 four 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 two 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 (D5670, D5671):

(A) Is covered for clients age 16 and older a maximum of once every ten (10) years, per arch;

(B) Ten years or more shall 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 ten 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 shall be documentation of a current reline that 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 five 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.

(9) 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 shall 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.

(10) 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 condition or diagnosis, 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 or 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 ICD-10 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 or 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, the CCO 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 shall 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, 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.

(11) ORTHODONTIA SERVICES:

(a) The Division limits orthodontia services and extractions to eligible clients:

(A) With the ICD-10-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 shall be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record shall 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 shall 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.

(12) 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 (D9223 and D9243);

(B) The Division reimburses providers for general anesthesia or IV sedation as follows:

(i) D9223 or D9243: For each 15-minute period, up to three and a half hours on the same day of service;

(ii) 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 shall 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

Stats. Implemented: ORS 414.065

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; DMAP 68-2013, f. 12-5-13, cert. ef. 12-23-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 10-2014(Temp), f. & cert. ef. 2-28-14 thru 8-27-14; DMAP 19-2014(Temp), f. 3-28-14, cert. ef. 4-1-14 thru 6-30-14; DMAP 36-2014, f. & cert. ef. 6-27-14; DMAP 56-2014, f. 9-26-14, cert. ef. 10-1-14; DMAP 7-2015(Temp), f. & cert. ef. 2-17-15 thru 8-15-15; DMAP 28-2015, f. & cert. ef. 5-1-15; DMAP 46-2015(Temp), f. 8-26-15, cert. ef. 10-1-15 thru 3-28-16; DMAP 51-2015, f. 9-22-15, cert. ef. 10-1-15; DMAP 65-2015, f. 11-3-15, cert. ef. 12-1-15; DMAP 74-2015(Temp), f. 12-18-15, cert. ef. 1-1-16 thru 6-28-16; DMAP 5-2016(Temp), f. & cert. ef. 2-9-16 thru 6-28-16; DMAP 36-2016, f. 6-30-16, cert. ef. 7-1-16; DMAP 45-2016, f. & cert. ef. 7-13-16

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Oregon Health Authority, Health Systems Division: Mental Health Services
Chapter 309

Rule Caption: Temporary adoption of new rules regarding certifications of behavioral health treatment services.

Adm. Order No.: MHS 6-2016(Temp)

Filed with Sec. of State: 6-28-2016

Certified to be Effective: 7-1-16 thru 12-27-16

Notice Publication Date:

Rules Adopted: 309-008-0100, 309-008-0200, 309-008-0250, 309-008-0300, 309-008-0400, 309-008-0500, 309-008-0600, 309-008-0700, 309-008-0800, 309-008-0900, 309-008-1000, 309-008-1100, 309-008-1200, 309-008-1300, 309-008-1400, 309-008-1500, 309-008-1600

Subject: (1) Purpose. These rules establish procedures for the application, initial certification, renewal of certification, review, and other actions on a certificate including revocation, denial, suspension, and placement of conditions for the behavioral health treatment services for the types listed in subsection (2) of this rule.

(2) Scope. These procedural rules apply to providers of behavioral health treatment services seeking certification to provide services issued under the referenced service delivery rules:

(a) OAR 309-014-0000 to 0040 (Mental Health Division Community Mental Health and Developmental Disability Services Contractors);

(b) OAR 309-018-0100 to 0215 (Residential Substance Use Disorders Treatment and Recovery Services and Residential Problem Gambling Treatment and Recovery Services);

(c) OAR 309-019-0100 to 0220 (Outpatient Addictions and Mental Health Services);

(d) OAR 309-022-0100 to 0190 (Intensive Treatment Services for Children and Adolescents);

(e) OAR 309-022-0195 to 0230 Children's Emergency Safety Intervention Specialist);

(f) OAR 309-033-0700 to 0740 (Community Hospital and Non-hospital Facilities to provide Seclusion and Restraint to Committed Persons and Persons in Custody or in Diversion);

(g) OAR 309-039-0500 to 0580 (Non-Inpatient Mental Health Treatment Services);

(h) OAR 415-020-0000 to 0090 (Out-Patient Opioid Treatment Programs);

(i) OAR 415-054-0020 to 0580 (DUII Alcohol/Other Drug Information and DUII Alcohol/Other Drug Rehabilitation Programs);

(j) OAR 415-054-0400 to 0580 (Alcohol and Drug Evaluation and Screening Specialist);

(k) OAR 415-055-0000 to 0035 (Recommendations For Restricted License For Driving Under The Influence of Intoxicants and Other Related Suspensions and/or Revocations; and

(l) OAR 415-057-0020 to 0150 (Adult Prison-Based Alcohol and Other Drugs Treatment Programs for the Department of Corrections).

(3)These rules do not establish procedures for other health care services types or licenses not listed in subsection (2) of this rule and specifically do not establish procedures for:

(a) Licensing a residential facility under ORS 443.410 or 443.725;

(b) Licensing or certifying an individual behavioral health care practitioner otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board; or

(c) Licensing or certifying a behavioral health treatment services provider comprised exclusively of health care practitioners or behavioral health care practitioners otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board.

Rules Coordinator: Nola Russell—(503) 945-7652

309-008-0100

Purpose and Scope

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(2) Scope. These procedural rules apply to providers of behavioral health treatment services seeking certification to provide services under the referenced service delivery rules:

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(c) Licensing or certifying a behavioral health treatment services provider comprised exclusively of health care practitioners or behavioral health care practitioners otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0200
Definitions

(1) "ASAM PCC" means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care, and incorporated by reference in these rules.

(2) "Applicant" means any provider with an existing certificate listed in OAR 309-008-0100(2) to provide behavioral health treatment services or any person, organizational provider, tribal organization, or Community Mental Health Program seeking initial certification listed in OAR 309-008-0100(2) by submitting an application to provide behavioral health treatment services.

(3) "Behavioral Health" means mental health, mental illness, addictive health, and addiction and gambling disorders.

(4) "Behavioral Health Treatment Services" means mental health treatment, substance use disorder treatment, and problem gambling treatment services.

(5) "Certificate" means the document or documents issued by the Division, which identifies and declares certification of a provider pursuant to these rules. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

(6) "Certification Review" means an assessment of a provider or applicant by the Division or by another state agency or contractor on behalf of the Division, for the purpose of assessing compliance with these rules, with applicable service delivery rules, and other applicable regulations.

(7) "Community Mental Health Program" (CMHP) means the organization of various services for persons with a mental health diagnosis or addictive disorders, operated by, or contractually affiliated with, a local mental health authority and operated in a specific geographic area of the state under an agreement with the Division pursuant to OAR 309-014-0000.

(8) "Condition" means a provision attached to a new or existing certificate that limits or restricts the scope of the certificate or imposes additional requirements on the applicant or provider.

(9) "Coordinated Care Organization" (CCO) means an entity that has been certified by the Authority to provide coordinated and integrated health services.

(10) "Director" means the Director of the Oregon Health Authority or the Director's designee.

(11) "Division" means the Health Systems Division (HSD) of the Oregon Health Authority or the Division's designee.

(12) "Division Staff" means those staff employed by the Division to conduct certification activities under these rules or a contracted entity delegated the authority by the Division to conduct certification activities under these rules.

(13) "Individual" means the person requesting or receiving behavioral health treatment services from a provider certified by the Division pursuant to these rules.

(14) "Individual Services Records" means documentation, written or electronic, regarding an individual including information relating to entry, assessment, orientation, services and supports planning, services and supports provided, and transfer.

(15) "Initial Certification" means a certificate issued to a new provider.

(16) "Non-Inpatient Provider" means a provider not contractually affiliated with the Division, a CMHP, or other contractor of the Division, providing behavioral health treatment services under group health insurance coverage which seeks or maintains Division approval under ORS 743A.168)

(17) "Oregon Health Authority" (Authority) 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, divisions of the Oregon Health Authority include the Public Health Division and the Health Systems Division.

(18) "Plan of Correction" (POC) means a written plan and attached supporting documentation created by the provider when required by the Division to address findings of noncompliance with these rules or applicable service delivery rules.

(19) "Provider" means a person, organizational provider as defined in ORS 430.637(1)(b), tribal organization, or CMHP that holds a current certificate listed in OAR 309-008-0100(2) to provide behavioral health treatment services pursuant to these and applicable service delivery rules.

(20) "Program Staff" includes employees of the provider, persons who provide services by contract with the provider, program administrators, directors, or others who manage the provision of services, and the provider itself where the provider is a person or a group of persons.

(21) "Program Director" means a person with appropriate professional qualifications and experience as regulated by the applicable service delivery rules listed on the certificate, who is designated to manage the operation of a program.

(22) "Public Funds" means financial support, in part or in full, provided directly or indirectly by a local, state, or federal government.

(23) "Regulatory Standard" means a rule, condition, or requirement describing the following information for products, systems, or practices:

(a) Classification of components;

(b) Specification of materials, performance, or operations; or

(c) Delineation of procedures.

(24) "Service Delivery Rules" means the OAR describing the specific regulatory standards for each of the types of behavioral health treatment services the Division certifies under these rules and as listed in OAR 309-008-0100(2).

(25) "Service Delivery Location" means the office, facility, location, or other physical premises where the applicant or provider intends to provide or currently provides behavioral health treatment services. .

(26) "Services" means those activities and treatments intended to assist the individual's transition to recovery from a substance use disorder, gambling disorder or mental health condition, and to promote resiliency, and rehabilitative and functional individual and family outcomes.

(27) "Substantial Compliance" means a level of adherence to applicable administrative rules, statutes, and other applicable regulations which even if one or more requirements is not met, does not, in the determination of the Division:

(a) Constitute a danger to the health, welfare or safety of any individual or to the public;

(b) Constitute a willful, negligent, or ongoing violation of the rights of any individuals as set forth in administrative rules; or

(c) Constitute impairment to the accomplishment of the Division's purposes in approving or supporting the applicant or provider.

(28) "Substantial Failure to Comply" means a level of adherence to applicable administrative rules, statutes, contractual requirements, and other applicable regulations, which in the determination of the Division:

(a) Constitutes a danger to the health, welfare or safety of any individual or to the public;

(b) Constitutes a willful, negligent, or ongoing violation of the rights of individuals as set forth in applicable administrative rules; or

(c) Constitutes impairment to the accomplishment of the Division's purposes in approving or supporting the applicant or provider.

(29) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0250
Required Certifications for Behavioral Health Treatment Services

(1) A current certificate is required for each provider offering behavioral health treatment services by contract with the Division, by contract with a public body, or by receipt of other public funds except as provided

in subsection (4) of this rule. A provider is considered to contract with a public body or receive public funds where:

(a) The provider operates under an intergovernmental agreement, a direct contract with the Division, or a direct contract with one or more CCOs;

(b) The provider receives funds administered by the Division or one or more CCOs;

(c) The provider is a community hospital, regional acute care psychiatric facility, or nonhospital facility providing care, custody, and treatment for a committed person in custody, or a person on diversion pursuant to ORS 426.070 & 426.140; and

(d) The provider is a CMHP operating under 309-014-0000.

(2) A current certificate is required for each provider offering behavioral health treatment services by contract with the Division, by contract with a public body, or by receipt of other public funds for the following types of behavioral health treatment services:

(a) A publicly or privately operated program as defined in ORS 430.010 that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with alcohol and other drug dependence, consistent with Level III of ASAM PCC, as regulated under OAR 309-18-0100 to 0215.

(b) Residential mental health treatment services offering mental health treatment services beyond the scope of their residential licensure issued under OAR 309-035-0000; and

(c) A publicly or privately operated program that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with gambling related problems, as regulated under OAR 309-018-0100 to 0215.

(3) An applicant or provider not described in subsection (1) or (2) of this rule offering behavioral health treatment services regulated by the service delivery rules listed in 309-008-0100(2), and reimbursable under group health coverage as set forth in ORS 743A.168, may seek certification pursuant to these rules in order to establish reimbursement eligibility.

(4) A certificate under these rules is not required for the following types of providers regardless of whether public funds are received:

(a) An individual behavioral health care practitioner otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board; or

(b) A behavioral health treatment services provider comprised exclusively of health care practitioners or behavioral health care practitioners otherwise licensed to render behavioral health care services in accordance with applicable statutes by the applicable licensing board, independent of payer or funding source.

(5) Certificates are not a substitute for a required license, such as those required in ORS 443.410 and 443.725 for residential facilities.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0300

Terms of Certification

(1) Each applicant and provider agrees, as a term of certification:

(a) To permit Division staff to inspect the service delivery location(s) where the applicant or provider intends to provide or currently provides behavioral health treatment services:

(A) During regular business hours and at any other reasonable hour to verify information contained in the application or to ensure compliance with all applicable statutes, administrative rules, other applicable regulations, or contractual obligations; and

(B) For immediate entry and inspection, extending to any premises the Division has reason to believe a provider provides behavioral health treatment services.

(b) To permit Division staff to inspect, audit, assess and collect data or copies from all records maintained by the applicant or provider in relation to the certificate including but not be limited to:

(A) Financial records;

(B) Individual Service Records;

(C) Records related to the supply, storage, disbursement, and administration of prescribed and over-the-counter medications;

(D) Records of utilization and quality assurance reviews conducted by the applicant, provider, or other accredited entity;

(E) Employee records including, but not limited to:

(i) Academic degrees;

(ii) Professional licenses;

(iii) Supervision notes, disciplinary actions, and logs; and

(iv) Criminal background checks;

(v) All documentation required by applicable service delivery rules, statute, other applicable regulations, and administrative rules;

(vi) Additional documentation deemed necessary by the Division to determine compliance with this or any other applicable administrative rules, statutes, or other applicable regulations;

(c) That the provider is certified to provide only those services which are specified in the scope of services and conditions listed on the certificate

(d) To post the certificate or a legible copy and any accompanying letter noting approved service delivery locations or applicable conditions in a public space of each approved service delivery location to be available for inspection at all times;

(e) That the certificate does not create an express or implied contract in the absence of a fully executed written contract; and

(f) That the certificate is not transferable to any other person, provider, or service delivery location without Division approval.

(2) Nondiscrimination; Special Populations: The Division shall not discriminate in its review procedures or services on the basis of race, color, national origin, age, or disability. The Division may issue certificates to specialized programs to assure maximum benefit for special populations, in which case, the Division may identify that special population in the certificates and impose applicable program criteria under the applicable service delivery rules.

(3) A certificate is void immediately:

(a) Upon voluntary closure by a provider;

(b) Upon change in the provider's majority or controlling ownership; or

(c) Upon the listed expiration date of the certificate if the provider fails to timely submit a complete application for certification renewal pursuant to these rules;

(4) Discontinuation of services:

(a) A provider discontinuing services voluntarily must:

(A) Notify the Division at least 60 days prior to the date of voluntary closure and provide a written pl an to comply with record retention standards set out in OAR 309-014-0035(4) and 42 CFR Part 2, "Federal Confidentiality Regulations" as applicable;

(B) Make reasonable and timely efforts to obtain alternative treatment placement or other services for individuals currently being served; and

(c) Make reasonable and timely efforts to contact individuals on waitlists and refer them to other treatment services; and

(d) A provider discontinuing services must provide individuals with a minimum 30-day written notice regarding discontinuation of services. In circumstances where undue delay might jeopardize the health, safety, or welfare of individuals or the public, including where the Division has revoked or immediately suspended the certificate pursuant to OAR 309-008-1100, the provider must notify individuals regarding the discontinuation of services as soon as possible.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0400

The Application Process

(1) Application Required. An applicant seeking initial certification or certification renewal, and an existing provider seeking to expand its certified scope of services, relocate an existing service delivery location, or open new service delivery location(s) must submit a completed application to the Division.

(2) The Division will furnish an application with instructions, and provide appropriate technical assistance to facilitate completion of the application, upon:

(a) Request from an applicant seeking initial certification;

(b) Request from an existing provider seeking certification renewal congruent with timelines established by these rules;

(c) Request from an existing provider seeking to add or relocate service delivery location(s); and

(d) Request from an existing provider seeking to change the scope of services approved on the current certificate.

(3) An applicant with multiple service delivery locations must submit documentation with the application sufficient for the Division to evaluate each service delivery location. A separate application for each service delivery location is not required.

(4) The application must be legible and completed on the forms furnished by the Division, in the manner specified by the Division. Each application must include:

(a) A detailed plan outlining the implementation of the proposed services congruent with these rules, applicable service delivery rules, other applicable regulations, and OAR and ORS noted herein;

(b) Written attestation by the applicant that all applicable rules of the Division for provision of the proposed services will be met and maintained in substantial compliance with applicable service delivery rules;

(c) Other documentation required by applicable OAR, ORS, other applicable regulations, local regulations, contract or by judgment of the Division to assess applicant's compliance with administrative rules; and

(d) Complete and current copies of the following documents:

(A) A description of the applicant's service delivery location(s) describing the type and scope of behavioral health treatment services provided or proposed by the applicant at each service delivery location;

(B) Applicant's policies regarding credentialing practices of individual practitioners;

(C) Applicant's liability insurance coverage listing all covered service delivery location(s);

(D) Applicant's policies and procedures regarding seclusion and restraint practices; and

(E) Applicant's Code of Conduct.

(5) Where applicable, the Division will maintain copies of the documents listed in subsection (4)(d) of this rule within the Division's CCO document bank.

(6) Timeframe for application submission:

(a) Initial Certification: An applicant seeking initial certification under these rules must submit a completed application at least six months in advance of the applicant's desired date of certification;

(b) Certification Renewal: An applicant seeking to renew its certificate must:

(A) Request an application from the Division; and

(B) Submit a complete application at least six months prior to the expiration of the existing certificate.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0500
Response to Application

(1) Upon receipt of application materials, the Division will conduct a comprehensive audit of the application materials to determine compliance with these rules.

(a) Complete Application. Within 60 days of the Division's receipt of a complete application compliant with these rules:

(A) The Division will notify the applicant that the application has been accepted as complete; and

(B) The Division will contact the applicant to schedule a certification review.

(b) Incomplete Application. Within 60 days of the Division's receipt of an incomplete application, the Division will provide written feedback describing any necessary amendment to the application prior to resubmission. To resubmit, the applicant must submit an amended application to the Division for review within 21 calendar days of receipt of the Division's written feedback.

(2) When an application is denied, the Division will issue a written notice of denial within 14 days of the determination in accordance with ORS 183.

(3) Applications for certification will be denied where:

(a) The applicant's proposed behavioral health treatment services are not subject to the service delivery rules listed in OAR 309-008-0100(2) and therefore are not subject to certification under these rules;

(b) The applicant fails to demonstrate substantial compliance with applicable statutes, administrative rules, or other applicable regulations.

(c) The applicant fails to re-submit complete application materials within 21 calendar days of receipt of the Division's written feedback;

(d) The applicant timely re-submits the application but the Division finds the re-submitted application remains incomplete or fails to demonstrate substantial compliance with applicable statutes, administrative rules, or other applicable regulations;

(e) The applicant submits an application within 180 days of a prior application denial or certificate revocation under these rules by the Division.

(4) The Division may elect to deny an application prior to review when:

(a) The applicant has previously had any certification or license suspended or revoked by the Division, Oregon Health Authority, the Oregon Department of Human Services, or any other similar state agency outside of Oregon;

(b) The applicant has been denied certification due to failure to submit complete application materials two or more times within the previous three calendar years;

(c) The applicant is listed on any current Medicaid exclusion list under OAR 410-120-1380(1)(c)(J); or

(d) The applicant submits false or inaccurate information to the Division.

(5) Withdrawal of Application. An applicant may withdraw an initial or renewal application at any time prior to the Division acting on the application unless the Division has determined that the applicant submitted false or misleading information in which case the Division may refuse to accept the withdrawal and may issue a notice of proposed denial in accordance with this rule.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0600
Appealing Denial of Application for Certification

(1) Hearing. Where the Division has denied an application under these rules, the Division must notify the applicant in writing and provide the applicant the opportunity to request a hearing under ORS Chapter 183. Any request for a contested case hearing must be submitted in writing to the Division by the applicant according to the deadline set out in the notice of denial.

(2) Review by the Division. Where the Division has denied an application under these rules, in addition to, or in lieu of, a hearing under ORS Chapter 183, an applicant may request, in writing, an appeal review by the Director.

(a) To obtain review, the applicant must submit a written request for the appeal review to the Division within fourteen (14) calendar days of receipt of the notice of denial;

(b) The Director, whose decision is final, must conduct an appeal review meeting within 30 days of receipt of the applicant's written request;

(c) If the Director overturns the denial, the Division will issue written notice to the applicant within fourteen (14) calendar days of the appeal review meeting. The notice will inform the applicant of the outcome of their appeal hearing and will either:

(A) Include an approved certification per these rules; or

(B) Include written notice of required amendment to application materials and a timeframe for re-submission per these rules.

(d) If the Director affirms the denial, the notice of denial will become final, the application closed, and a notice of the appeal review outcome mailed to the applicant within fourteen (14) days of the appeal review meeting.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0700
Types of Reviews

(1) The Division may conduct the following types of certification reviews as appropriate:

(a) Initial Certification Review. After receipt of a complete application and consistent with OAR 309-008-0500(1)(a)(B), Division staff will complete a comprehensive audit of the required application documentation and the service delivery location(s). The Division will not issue an initial certification without a completed Initial Certification Review;

(b) Certification Renewal Review. After receipt of a complete application and consistent with OAR 309-008-0500(1)(a)(B), Division staff will complete a comprehensive audit of the required application documentation and the service delivery location(s). For continued certification, Certification Renewal Reviews must occur prior to the expiration of the existing certificate and at least once every three years;

(c) Discretionary Certification Reviews. The Division may conduct Discretionary Certification Reviews with reasonable notice to ensure com-

pliance with applicable statute, administrative rules, other applicable regulations, and contractual obligations.

(A) Discretionary Certification Reviews may be conducted by the Division with or without notice for the following reasons:

(i) The Division has reasonable concern the provider may act to alter records or make them unavailable for inspections;

(ii) The Division has received a complaint or information which suggest or allege conditions or practices which could threaten the health, safety, rights, or welfare of individuals; or

(iii) The Division has reason to believe a certification review is necessary to ensure a provider is in substantial compliance with these rules, service delivery rules, other applicable administrative rules, contractual obligations or with conditions placed upon the certificate;

(5) If Division staff are not permitted access to records or service delivery location(s) for the purpose of conducting a certification review consistent with these rules, the Division may take action on the certificate up to and including the application of conditions, suspension, or revocation.

(6) Inspections By Other Agencies: A provider or applicant must permit state or local fire inspectors and state or local health inspectors to enter and inspect the service delivery location(s) as required by administrative rule, state fire code, or local regulations.

(7) Desk Reviews. At the sole discretion of the Division, Division staff may complete a certification review partially or fully via a desk review process. A desk review process is where Division staff conduct a certification review based on the provider or applicant's submission of required documentation and telephonic interviews where Division staff do not physically visit the service delivery location(s).

(a) The Division will furnish a list of documentation necessary to complete the desk review to the applicant or provider;

(b) The applicant or provider must submit all requested documents to the Division in compliance with state and federal privacy and data transmission regulations;

(c) The Division may elect to schedule telephone interviews deemed necessary to fulfill the objectives of a certification review; and

(d) Upon completion of the desk review, the Division will securely dispose of documentation containing protected health information submitted by the applicant or provider.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0800

Conduct of Certification Reviews

(1) The Division will employ review procedures deemed adequate to determine applicant or provider compliance with applicable administrative rules, statutes, other applicable regulations, and as necessary, contractual obligations. These procedures may include but are not limited to:

(a) Entry and inspection of any service delivery location(s);

(b) Review of documents pursuant to this rule; and

(c) Interviews with or a request for completion of a questionnaire, by persons knowledgeable of the provider or applicant. Individuals interviewed may include program staff, managers, governing or advisory board members, allied agencies, individuals, their family members, and significant others;

(2) Program staff must cooperate with Division staff during a certification review.

(3) Within 30 days following the completion of each discretionary review the Division may, at their discretion, issue a report and require a Plan of Correction congruent with section (4) of this rule.

(4) Within 30 days following the completion of each initial or renewal certification review the Division will issue a report including:

(a) A statement of deficiency including a description of the review findings related to non-compliance with applicable administrative rules, statutes, other applicable regulations and any required corrective actions where applicable;

(b) Conditions the Division intends to include on a certificate, when applicable;

(c) The Plan of Correction (POC): When pursuant to a certification review, the Division determines a provider or applicant is not operating in substantial compliance with all related statutes, administrative rules and other applicable regulations and the plan of correction process is appropriate, the Division may require the provider or applicant to submit a POC. The Division will provide written notice of the requirement to submit a POC and the provider or applicant must prepare and submit a POC according to the following terms:

(A) The provider or applicant must submit the POC to the Division within 30 days of receiving the statement of deficiency. The Division may issue up to a 90 day extension to the existing certification to allow the provider or applicant to complete the plan of correction process.

(B) The POC must address each finding of non-compliance and must include:

(C) The planned action(s) or action(s) already taken to correct each finding of non-compliance;

(D) The anticipated or requested timeframe for the completion of each corrective action not yet complete at the time of POC submission to the Division;

(E) A description of and plan for quality assurance activities intended to ensure ongoing compliance; and

(F) The person(s) responsible for ensuring the implementation of each corrective action within the plan of correction;

(d) POC Clarification Necessary. If the Division finds that clarification or supplementation to the POC is required prior to approval, Division staff will contact the provider or applicant to provide notice of requested clarification or supplementation, and the provider or applicant will submit an amended plan of correction within 14 calendars days of notification.

(e) The provider must submit a sufficient POC approved by Division prior to receiving a certificate. Upon the Division's approval of the POC, the Division will issue the appropriate certification pursuant to these rules.

(f) Failure to Submit POC. The Division may deny, suspend, or revoke an applicant or provider's certification if the provider fails to submit an adequate POC within the timeframes established in this rule.

(5) Substantial Compliance. When the Division determines a provider or applicant to be in substantial compliance with all related statutes, administrative rules and other applicable regulations, the Division will not require a POC. For certification reviews conducted for purposes of initial certification or renewal of a certification, the Division will issue a certificate pursuant to these rules.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-0900

Issuing Certificates

(1) Issuing Certificates. The Division will issue an approved applicant a certificate to provide behavioral health treatment services as follows:

(2) Every certificate will;

(a) Be signed by the Director;

(b) Apply to all approved service delivery locations listed in the accompanying letter;

(c) List the service delivery rules under which the applicant or provider is approved to provide services;

(d) List the effective and expiration dates of the certificate;

(e) List any conditions applied to the certificate;

(f) List any variances approved by the Division; and

(g) Be accompanied by a letter from the Division noting:

(A) All service delivery locations approved under the certificate; and

(B) Approved alternative practices related to variances listed on the certificate

(3) Initial Certification. After conduct of the certification review, the Division will issue initial certificates to new applicants that demonstrate substantial compliance with applicable administrative rules and statutes:

(a) For up to one (1) calendar year from the date of initial certification; and

(b) Initial certifications may be issued with conditions pursuant to this rule.

(4) Certification Renewal. After conduct of the certification review, and the plan of correction process where applicable, the Division will renew the certificate of an applicant with a current certification that demonstrate substantial compliance with applicable administrative rules, or statutes:

(a) For up to three (3) calendar years from the date of renewal; and

(b) Renewal certifications may be issued with conditions pursuant to this rule.

(5) Certificates with Conditions. The Division may elect at any time and at its discretion to place time-limited conditions on a certificate upon a finding that:

(a) The applicant or provider employs or contracts with any program staff who has mistreated or otherwise engaged in abusive behavior or has been substantiated for abuse or mistreatment;

(b) The applicant or provider employs or contracts with any program staff that fails to meet relevant minimum qualifications per the applicable service delivery rule(s);

(c) The applicant or provider is substantiated for abuse or mistreatment;

(d) The applicant or provider operates such that there is a threat to the health, welfare, or safety of an individual or the public;

(e) The applicant or provider fails to operate in substantial compliance with these or other applicable administrative rules or regulations;

(f) The applicant or provider fails to fully implement or adequately maintain a corrective action required by an approved POC;

(g) The Division has issued the applicant or provider through two or more consecutive certification reviews substantially similar finding(s) of non-compliance with these rules, service delivery rules, or other applicable administrative rules, statutes or regulations;

(h) There is a need for increased regulatory oversight of the applicant or provider;

(i) The applicant or provider fails to comply with any reporting requirements relating to funding or certification; or

(j) The applicant or provider is unable to comply with applicable rules or regulations due to staffing shortfalls; or

(k) The applicant or provider qualifies for placement of a condition on the certificate pursuant to applicable service delivery rules.

(6) The Division will consider the sum of the circumstances, including the following criteria, when deciding whether to issue a certificate with conditions as opposed to denying, suspending, refusing to renew, or revoking a certificate;

(a) The expressed willingness and demonstrated ability of the applicant or provider to gain and maintain compliance with all applicable administrative rules and regulations;

(b) Submission of a POC prescribing reasonable, sustained and timely resolution to areas of non-compliance;

(c) The relative availability of alternative providers to address any service needs that would be unmet if the applicant or provider is not issued a certificate with conditions as an alternative to revocation or refusal to award a certificate; or

(d) The applicant or provider's historical compliance with Division rules, previous conditions placed on certificates, and previous POCs.

(7) Conditions to the certificate may include:

(a) Requiring corrective actions with associated timeframes for completion necessary for the applicant or provider to correct areas of non-compliance or concern identified by the Division;

(b) Limiting the total number of individuals enrolled in services or on a waitlist for services;

(c) Limiting the demographics including the age range of individuals who may by the applicant or provider;

(d) Limiting the scope and type of services that the applicant or provider may provide;

(e) Other conditions deemed necessary by the Division to ensure the health and safety of individuals and the public; and

(f) Other conditions deemed necessary by the Division for the purpose of ensuring regulatory compliance with this or other applicable administrative rules and regulations.

(8) The Division will:

(a) List the conditions on the certificate;

(b) Notify the applicant or provide in writing the condition(s) imposed; and

(c) The duration of the condition(s), and actions required for the removal of the condition from the certificate.

(9) Duration of Conditions. The Division will determine the duration of each condition listed on a certificate. Conditions will:

(a) Be issued for no longer than one (1) year;

(b) Be removed from the certificate when the applicant or provider demonstrates the successful completion of actions required the Division.

(10) Extension of Conditions. Upon an applicant or provider's application, the Division may in its discretion grant a request for an extension for no longer than six (6) months beyond the initial condition period.

(a) The applicant or provider's request for extension must be in writing and received by the Division at least 30 calendar days prior to the expiration date of the condition listed on the certificate;

(b) The applicant or provider's request for extension must include a detailed explanation of the following for each condition to which the applicant or provider seeks an extension:

(A) Actions taken by the applicant or provider to complete the required action necessary for removal of the condition;

(B) An explanation of why any required actions will not be completed prior to the condition's expiration date;

(C) A plan detailing how and when the applicant or provider will complete the required actions necessary to remove the extended condition, not to exceed six (6) months; and

(D) An explanation as to the extenuating circumstances prohibiting the applicant or provider's timely completion of the required actions.

(c) Conditions will not be extended:

(A) Where the request for extension is not received by the Division in advance of the condition expiration date;

(B) Where the Division has already granted one extension;

(C) Where the Division finds that an extension would perpetuate significant health and safety issues;

(D) Where the condition is the result of repeated findings of non-compliance; or

(E) Where the Division finds that If the applicant or provider fails to demonstrate extenuating circumstances.

(11) The Division may deny, suspend, and refuse to renew, or revoke the certificate where the provider or applicant fails to timely complete required corrective actions for removal of the condition(s).

(12)(a) When the Division orders a condition be placed on a certificate under the provisions of this rule, the applicant or provider is entitled to request a hearing in accordance with ORS Chapter 183;

(b) In addition to, or in lieu of, requesting a hearing in accordance with ORS Chapter 183, an applicant or provider may request an informal conference with the Division per the informal conference process found in OAR 309-008-0600.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1000

Modification to Certification

(1) Modifying Certificates. A provider with a current certificate seeking to open new service delivery location(s), relocate current service delivery locations, provide additional types of treatment services under different service delivery rules must submit a written request for Division approval prior to any such changes.

(a) The Division must receive the written request for such changes at least 60 days prior to the desired effective date for any such changes.

(b) The Division will make reasonable efforts to make final determination for approval or disapproval of changes to the certificate within 45 days of receiving the written request;

(2) A provider with a current certificate seeking to designate a new Program Director must submit a written request for Division approval prior to making such a designation.

(a) The provider must include copies of relevant qualifications with its written request when designating a new Program Director.

(b) The Division will make every reasonable effort to review documents and make a final determination regarding whether the proposed Program Director meets applicable service delivery rule requirements and qualifications within 30 days of receipt of the provider's written request. The Division will provide written notice of its determination;

(c) When an emergency requires a provider to designate a new Program Director prior to Division approval:

(A) The provider must make every reasonable effort to expediently designate a new Program Director and must submit a request for the designation to the Division within 15 calendar days of the new designation and include copies of relevant qualifications of the new Program Director; and

(B) The Division will make every reasonable effort to expediently review the provider's request for the designation and make a final determination whether the proposed Program Director meets applicable service delivery rule requirements. The Division will provide written notice of its determination.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1100
Suspension and Revocation of Certification

(1)(a) Immediate Revocation or Suspension. Immediate Revocation or Suspension of a certificate, may occur when the Division finds there is substantial failure to comply with applicable statutes, administrative rules, service delivery rules, or other applicable regulations, such that, the Division finds that there is a serious danger to the public health or safety:

(b) Has demonstrated substantial failure to comply with these administrative rules and other applicable regulations such that the health or safety of individuals is jeopardized to the degree that immediate cessation of services by the provider is considered necessary to prevent harm to the individual.

(2) Revocation, Suspension, and Refusal to Renew Certificates with Notice. The Division may, with a 30 day notice to revoke, suspend or refuse to renew a certificate or one or more service delivery locations listed on the certificate when the Division determines a provider:

(a) Has demonstrated substantial failure to comply with these administrative rules and other applicable regulations such that the health or safety of individuals is jeopardized to the degree that cessation of services by the provider is considered necessary to prevent harm to the individual;

(b) Has demonstrated a substantial failure to comply with applicable rules and regulations such that the health or safety of individuals is found to be jeopardized during two certification reviews within a six-year period;

(c) Has failed to maintain any State of Oregon license which is a prerequisite for providing services that were approved;

(d) Has a direct contract with the Division and the Division has terminated its agreement or contract with the provider;

(e) Has failed to correct the issues detailed in a certificate with conditions within the allotted time;

(f) Has failed to submit a POC sufficient to come into substantial compliance with these and other applicable rules or regulations;

(g) Has submitted falsified or incorrect information to the Division;

(h) Has refused to allow access to information for the purpose of verifying compliance with applicable statutes, administrative rules or other applicable regulations, within a specified date or fails to submit such information following the date specified for such a submission in the written notification.

(3) When the Division determines the need to revoke, suspend, or deny renewal of a certificate issued under these rules, a notice of intent to take action on the certificate will be issued to the provider.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1200
Informal Conference

(1) Informal Conference. Within ten (10) calendar days of the Division issuance of a notice of intent to apply a condition, revoke, suspend, or refusal to renew the certificate to an applicant or provider pursuant to these rules, the Division must offer the applicant or provider an opportunity for an informal conference. The applicant or provider must make its request for an informal conference in writing within seven (7) days of the issuance of notice. Upon receipt of a timely written request, the Division will select a location and time for such a conference, provided that the conference occurs within 14 days of the Division's receipt of the request.

(2) Following such a conference, the Division may:

(a) Approve the application or renewal, or set conditions to certification as described as allowed by these rules an alternative to denying or revoking certification;

(b) Continue to proceed with action on the provider's certificate up to and including applying conditions, suspension, revocation, or refusal to renew the certificate.

(3) The Division will provide written notice of its decision under subsection (2) of this rule within fourteen (14) calendar days of the informal conference.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1300
Hearings

(1) An applicant or provider issued a notice of intent to apply a condition, revoke, suspend, or refusal to renew its certificate under these rules shall be entitled to request a hearing in accordance with ORS Chapter 183.

(2) When the Division orders the immediate suspension or denial of a certificate under the provisions of this rule, the provider shall be entitled to request a hearing in accordance with ORS Chapter 183.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1400
Information to CCOs and Other Health Plans

(1) Upon completion of the site review process and the issuance of a certificate, the Division will make copies of the following information available to Coordinated Care Organizations and other health plans for the purpose of credentialing a provider:

(a) A current program description that reflects the type and scope of behavioral health treatment services provided by the provider;

(b) Provider policies and procedures regarding the provider's credentialing practices of individual clinicians;

(c) Statements of provider's liability insurance coverage;

(d) An attestation from the Division verifying that the provider has passed a screening and meets the minimum requirements to be a Medicaid provider, where applicable;

(e) Reports detailing the findings of the Division's certification review of the provider;

(f) The provider's Medicaid Vendor Identification Number issued by the Division, where applicable;

(g) Copies of the provider's policies and procedures regarding seclusion and restraint practices; and

(h) Copies of the provider's Code of Conduct.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1500
Complaints

(1) Complaints Concerning Providers. Any person may file a complaint with the Division concerning a provider holding a certificate under these rules. The Division may require the complainant to exhaust grievance procedures available through the provider and, if applicable, the Medicaid payer, prior to initiating an investigation.

(2) Complaint Investigation. The Division will only investigate a complaint concerning a provider falling within the Division's scope and regulatory authority;

(a) The Division will investigate and respond to a complaint pursuant to Division policies and procedures.

(b) The Division will refer the complainant to the appropriate entity if the complaint pertains to a provider falling outside the Division's scope or regulatory authority or otherwise regulated by another state or local entity.

(3) Consequences of a substantiated complaint related to the health, safety, or welfare of an individual or the public may result in the suspension, revocation, denial, or refusal to renew an applicant or provider's application or certificate.

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-008-1600
Variance

(1) An applicant or provider may requests a variance to these rules, applicable service delivery rules, or other applicable regulations.

(2) Variance Submission. The applicant or provider must submit the variance request directly to the Division along with the application documents submitted to the Division. The variance request must include:

(a) A description and applicable details of the variance requested, including the applicable section of the rule for which the variance is sought;

(b) The rationale and necessity for the requested variance;

(c) The alternative practice proposed, where relevant; and

(d) The proposed duration of the variance, including a plan and timetable for compliance with the rule exempted or adjusted by the variance.

(3) Outcome of Requests for Variance. The Director, whose decision is final, will approve or deny the variance request and include an expiration date for the variance not to exceed the length of the provider's current certificate.

(4) Variance Expiration. A variance granted by the Division becomes part of the certificate. Continuance of the variance will not be automatic, and will be re-considered at the expiration of the variance, or when the certification is being considered for renewal, whichever comes first.

(5) Variance Renewal. Requesting renewal of a variance in advance of current variance expiration is the responsibility of each provider.

(6) Failure to Implement Variance. Failure by the provider to implement approved alternative practices or otherwise demonstrate noncompliance with an approved variance may result in the Division withdrawing approval for a variance.

(7) Failure by the provider to implement approved alternative practices or otherwise demonstrate noncompliance with an approved variance such that the health or safety of individuals is jeopardized to the degree that cessation of services by the provider is considered necessary to prevent harm to the individual may result in the Division taking action on the certificate pursuant to OAR 309-008-1100

Stat. Auth.: ORS 161.390, 161.392, 179.040, 179.505, 413.042, 413.032-413.033, 426.072, 426.175, 426.236, 426.500, 430.010, 430.021, 430.256, 430.357, 430.560, 430.640, 430.870, 743A.168, 743.556.

Stats. Implemented: 413.520, 426.060, 426.140, 430.010, 430.254, 430.335, 430.590, 430.620, 430.637, 813.021, & 813.260.

Hist.: MHS 6-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Temporary suspension of OAR 309-012-0130 through 309-012-0230 regarding certificates for providing mental health services.

Adm. Order No.: MHS 7-2016(Temp)

Filed with Sec. of State: 6-28-2016

Certified to be Effective: 7-1-16 thru 12-27-16

Notice Publication Date:

Rules Suspended: 309-012-0130(T), 309-012-0140(T), 309-012-0150(T), 309-012-0160(T), 309-012-0170(T), 309-012-0180(T), 309-012-0190(T), 309-012-0200(T), 309-012-0210(T), 309-012-0220(T), 309-012-0230

Subject: These rules establish procedures for approval of the following kinds of organizations:

(1) Any mental health service provider which is, or seeks to be, contractually affiliated with the Division or community mental health authority for the purpose of providing services described in ORS 430.630(3);

(2) Performing providers under OAR 309-016-0070;

(3) Organizations seeking Division approval of insurance reimbursement as provided in ORS 743A.168; and

(4) Holding facilities.

Rules Coordinator: Nola Russell—(503) 945-7652

309-012-0130
Purpose and Scope

(1) Purpose. These rules establish procedures for approval of the following kinds of organizations:

(a) Any mental health service provider which is, or seeks to be, contractually affiliated with the Division or community mental health authority for the purpose of providing services described in ORS 430.630(3);

(b) Performing providers under OAR 309-016-0070;

(c) Organizations seeking Division approval of insurance reimbursement as provided in ORS 743A.168; and

(d) Holding facilities.

(2) These rules do not establish procedures for residential licensure under ORS 443.410 and 443.725.

(3) These rules do not establish procedures for regulating behavioral health care practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes.

(4) These rules do not establish procedures for regulating practices exclusively comprised of behavioral healthcare practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes.

Stat. Auth.: ORS 179.040, 430.640, 743A.168, 413.032-413.033, & 413.042

Stats. Implemented: ORS 179.505, 430.010 & 430.620

Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; MHS 9-2015(Temp), f. & cert. ef. 11-25-15 thru 5-20-16; Administrative correction, 6-21-16; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0140
Definitions

As used in these rules:

(1) "Applicant" is any entity potentially eligible to be approved as a provider under these rules and who has requested, in writing, a Certificate of Approval.

(2) "Certificate of Approval" is the document awarded under these rules signifying that a specific, named organization is judged by the Division to operate in compliance with applicable rules. A "Certificate of Approval" for mental health services is valid only when signed by the Assistant Administrator of the Division and, in the case of a subcontract provider of a CMHP, the CMHP director.

(3) "Community Mental Health Program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an agreement or contract with the Division.

(4) "Direct Contract" or "Contract" is the document describing and limiting the relationship and respective obligations between an organization other than a county and the Division for the purposes of operating the mental health program area within a county's boundaries, or operating a statewide, regional, or specialized mental health services.

(5) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(6) "Holding Facility" means hospitals or other facilities, including Division contracted acute care facilities, providing care, custody, and treatment of allegedly mentally ill persons under the emergency provisions of ORS 426.070 & 426.140.

(7) "Intergovernmental Agreement" or "Agreement" is the document describing and limiting the contractual relationship and respective obligations between a county or other government organization and the Division for the purpose of operating mental health services.

(8) "Letter of Approval" is the document awarded to service providers which states that the provider is in compliance with applicable administrative rules of the Division. Letters of Approval issued for mental health services are obsolete upon their expiration date, or upon the effective date of this rule, whichever is later. OAR 309-012-0010 is repealed upon the effective date of these rules.

(9) "Local Mental Health Authority" means the county court or board of county commissioners of one or more counties who operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public agency or private corporation with whom the Division directly contracts to provide the mental health services program area.

(10) "Mental Health Program Area" means the organization of all services for persons with mental or emotional disturbances, operated by or contractually affiliated with, a local mental health authority, in a specific geographic area of the state.

(11) "Mental Health Services Provider" means a corporate, or government entity, which provides a service defined in a Division administrative rule, under a contract or agreement with the Division, or CMHP.

(12) "Non-Inpatient Provider" means an organization not contractually affiliated with the Division, a CMHP, or other contractor of the Division providing services under group health insurance coverage for mental or nervous conditions which seeks or maintains Division approval under ORS 743.556(3).

(13) "Provider" means either a mental health services provider, holding facility, or a non-inpatient provider.

(14) "Service Element" means a distinct service or group of services for persons with mental or emotional disturbances which is defined in administrative rule and is included in a contract or agreement issued by the Division.

(15) "Subcontract" is the document describing and limiting the relationship and obligations between a government or other entity having an agreement or contract with the Division and a third organization (subcontractor) for the purpose of delivering some or all of the services specified in the agreement or contract with the Division.

(16) "Substantial Compliance" means a level of adherence to Division rules applicable to the operation of a service which, while not meeting one or more of the requirements in an exact, literal manner, does

not, in the determination of the Division, constitute a danger to the health or safety of any person, is not a willful or a potentially continuing violation of the rights of service recipients as set forth in administrative rules, or will not prevent the accomplishment of the State's purposes in approving or supporting the subject service. "Substantial failure to comply" is used in this rule to mean the opposite of "substantial compliance."

Stat. Auth.: ORS 179.040, 179.505, 426.175, 430.010, 430.640 & 743.556
Stats. Implemented: 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0150
Applicability of Certificates of Approval

Certificates of Approval are awarded to mental health services providers and non-inpatient providers that are found to be in substantial compliance with applicable administrative rules:

(1) Mental health services providers are required to maintain Certificates of Approval as follows:

(a) Each community mental health program or provider operating under an Intergovernmental Agreement or a direct contract with the Division must maintain a Certificate of Approval as set forth in these rules;

(b) Each local mental health service provider operating under subcontract with a CMHP must maintain a Certificate of Approval as set forth in these rules in order to receive funds administered by the Division through the local subcontract relationship.

(2) Hospitals and other facilities which operate as holding facilities in providing care, custody, and treatment of allegedly mentally ill persons under the emergency provisions of ORS 426.070 & 426.140 must maintain a Certificate of Approval as set forth in these rules.

(3) A provider not described above which offers services that may be reimbursable under group health coverage as set forth in ORS 743A.168 for mental or emotional conditions may seek to obtain a Division Certificate of Approval in order to establish reimbursement eligibility.

(4) Certificates of Approval are not awarded as a substitute for a license such as those required in ORS 443.410 and 443.725 for residential facilities. However, the Division may require such licensed providers to obtain a Certificate of Approval if services exceeding those required for licensure are provided in return for Division financial support as set forth in section (1) of this rule.

(3) These rules do not establish procedures for regulating behavioral health care practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes.

(4) These rules do not establish procedures for regulating practices exclusively comprised of behavioral healthcare practitioners that are otherwise licensed to render behavioral healthcare services in accordance with applicable statutes.

Stat. Auth.: ORS 179.040, 179.505, 426.175, 430.010, 430.640 & 743.556
Stats. Implemented: 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0160
Award of Certificates of Approval for New Applicants

(1) County governments and applicants for direct contracts with the Division. Counties not operating under an agreement with the Division, or those electing to add Division service elements which are not included in their agreement, and other organizations seeking to become direct contractors of the Division following the Division's request for such contractors, may be awarded Certificates of Approval based upon the following:

(a) A plan for the implementation of the proposed services which meets the specifications of the Division;

(b) Written assurance, by an officer with authority to obligate the applicant, that all applicable rules of the Division for operation of the proposed services will be met, or if not, operated in compliance with a waiver awarded by the Division; and

(c) Other reviews, such as those described in OAR 309-012-0190(3), which in the judgment of the Division may assist to predict compliance of the applicant's proposed services with administrative rules;

(d) Following the completion of the application process, and any reviews deemed necessary by the Division, the Division will make one of the following determinations:

(A) That the applicant may be awarded a Certificate of Approval based on demonstration of its capacity and willingness to operate in compliance with applicable administrative rules;

(B) That the applicant may be awarded a Certificate of Approval with specified conditions as described in OAR 309-012-0200; or

(C) That the applicant will not be awarded a Certificate of Approval because it has not demonstrated that it will comply with applicable administrative rules.

(2) Community mental health subcontracted providers, holding facilities, and performing providers:

(a) A provider seeking a Certificate of Approval for the first time, in order to operate as a CMHP subcontractor, performing provider under OAR 309-016-0070, or holding facility shall submit an application to the CMHP in the county in which the service will be offered;

(b) Upon a determination by the CMHP to subcontract with the provider for the purpose of providing a mental health service, for the purpose of operating as a performing provider under OAR 309-016-0070, or as a holding facility, the CMHP shall apply to the Division for a Certificate of Approval for the program;

(c) The CMHP application to the Division must include the following:

(A) Provider identifying information including corporate name, address, telephone number, and name of manager or director;

(B) Written assurance from an officer with authority to obligate the applicant that the applicant will operate in compliance with all administrative rules applicable to the services which will be subcontracted to the provider, or a request for a variance to the applicable administrative rules with which the provider will not comply.

(d) The Division may initiate other reviews such as those described in OAR 309-012-0190(3) and may negotiate with the CMHP, ongoing monitoring activities to be conducted to ensure the provider's compliance;

(e) Following the completion of the application process described above, and any reviews deemed necessary by the Division, the Division will make one of the following determinations:

(A) That the applicant may be awarded a Certificate of Approval based on demonstration of its capacity and willingness to comply with applicable administrative rules;

(B) That the applicant may be awarded a Certificate of Approval with specified conditions for action by the applicant for reaching substantial compliance with applicable administrative rules, and/or specific monitoring activities which have been negotiated with the CMHP as described in subsection (2)(d) of this rule;

(C) That the applicant will not be awarded a Certificate of Approval because it has failed to demonstrate that it will comply with applicable administrative rules, or that the kind and amount of monitoring proposed by the CMHP will not assure the applicant's compliance.

(f) Certificates of Approval awarded to CMHP subcontractors are issued jointly between the Division and the CMHP. To be valid, such a Certificate must bear the signature of the Assistant Administrator of the Division and the CMHP director.

(3) Non-inpatient providers seeking Division approval for insurance reimbursement purposes as provided in ORS 743.556(3). Non-inpatient providers seeking Division approval for insurance reimbursement purposes may correspond with the Division specifically requesting application instructions for Division approval as provided in ORS 743.556(3). Following a review of application materials submitted by the provider, the Division may:

(a) Deny the application, in writing, to the applicant because of a failure to pay the application fee described in subsection (d) of this section; because the application materials demonstrate that the provider does not comply with OAR 309-039-0500 through 309-039-0580; or because of the provider's failure to submit materials specified in the application instructions; or

(b) Following review of the application, the Division may:

(A) Schedule reviews such as those described in OAR 309-012-0190(4) by Division personnel; or

(B) Notify the applicant of other agencies or individuals with whom they may contract for the purpose of conducting a review and providing a report of program compliance to the Division;

(C) Notify the applicant of placement on a waiting list for review when Division staff or other agencies or individuals are available to conduct a review.

(c) Following the reviews in paragraph (b)(A) or (B) of this section, the Division will award or refuse to award a Certificate of Approval to the applicant based on the findings of the review;

(d) The Division may require payment of an application fee and a certification fee by non-inpatient programs applying or reapplying for a Certificate of Approval under these rules, provided the collection of such fees has been authorized for the Division budget by the Legislative Assembly or the Emergency Board.

Stat. Auth.: ORS 179.040, 179.505, 426.175, 430.010, 430.640 & 743.556
Stats. Implemented: 430.620

Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0170
Award of Certificates of Approval to Providers at the Time These Rules are Adopted

(1) Mental health services providers. Upon adoption of these rules, the Division may issue Certificates of Approval to mental health services providers that are operating under an Intergovernmental Agreement, direct contract, or at the request of the CMHP, to current subcontractors of the CMHP.

(2) Non-inpatient providers described in ORS 743.556 and holding facilities. Letters of Approval awarded under ORS 743.556 and those awarded to holding facilities which remain in effect at the time these rules are adopted, are the equivalent of a Certificate of Approval. These may be maintained and renewed as Certificates of Approval as set forth in these rules.

Stat. Auth.: ORS 179.040, 179.505, 426.175, 430.010, 430.640 & 743.556
Stats. Implemented: 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0180
Duration and Renewal of Certificates of Approval

(1) Mental health services providers. Unless revoked pursuant to OAR 309-012-0210 or unless otherwise specified on the Certificate, Certificates of Approval for mental health services providers are valid for three years.

(2) Non-inpatient providers. Certificates of Approval for providers described in ORS 743.556(3) are valid for up to three years or as otherwise specified on the Certificate. When a non-inpatient provider seeks a Certificate of Approval to be in effect at the expiration date of a Letter of Approval or a prior Certificate of Approval, an application conforming to the instructions of the Division must be received no later than 90 days prior to the expiration of the earlier Letter of Approval or Certificate.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0190
Conduct of Periodic and Interim Reviews

(1) Review Schedules:

(a) Periodic reviews of mental health service providers will be routinely conducted every three years;

(b) Periodic reviews of non-inpatient providers approved under ORS 743.556 will be conducted following the provider's submission of an application for recertification as set forth in OAR 309-012-0180;

(c) Interim reviews of any provider holding a Certificate of Approval may be conducted at any time at the discretion of the Division, or in the case of a subcontractor of a CMHP, at the discretion of either Division or the CMHP.

(2) Notification of Review. Notification that a review will be conducted, along with all instructions and requests for information from the provider, will be made in writing by the designee of the Assistant Administrator of the Division. For reviews of subcontractors initiated by the CMHP, notification and instructions will be made by the designee of the director of the CMHP.

(3) Initiation of Reviews:

(a) Reviews of new applicants, and periodic reviews will be scheduled with at least one month's notice from the Division to the CMHP, direct contractor, or non-inpatient provider. Subcontractors will be notified by the CMHP;

(b) The Division and, in the case of a subcontractor, the CMHP may conduct an interim review without prior notification when there is reason to believe any of the following conditions have occurred or may occur:

(A) Operations of the service provider threaten the health or safety of any person;

(B) The provider may act to alter records or make them unavailable for inspections.

(c) Interim reviews other than those specified in subsection (b) of this section will be initiated with at least two week's notice by the Division to the CMHP or direct contractor.

(4) Review Procedures. The Division, and in the case of reviewing a subcontractor, the CMHP, may employ review procedures which it deems adequate to determine compliance with applicable administrative rules. These procedures may include but are not limited to:

(a) Entry and inspection of any facility used in the delivery of approved services;

(b) A request for the submission to the Division or CMHP, of a copy of any document required by applicable administrative rules or needed to verify compliance with such rules, or access to such documents for on-site review. Such documentation could include, for example, records of utilization and quality assurance reviews, copies of portions of selected consumer records, and copies of staff academic degrees or professional licenses;

(c) The completion by the provider of self-assessment checklists reporting compliance or non-compliance with specific rule requirements; and

(d) Conduct of interviews with, and administration of questionnaires to persons knowledgeable of service operations, including, for example, staff and management of a provider, governing and advisory board members, allied agencies, service consumers, their family members, and significant others;

(e) In the case of subcontracts and reviews initiated by the county, the county may request Division assistance in conducting the reviews.

(5) Organizational Provider Assessment Information

(a) In addition to the review procedures outlined in Section 309-012-0057, the Division will ensure that the following minimum information will be obtained during the site reviews;

(b) A current program description that reflects the type and scope of behavioral health services provided by the applicant;

(c) Provider policies regarding credentialing practices of individual practitioners. The policies must reflect current credentialing standards as defined by nationally accepted accrediting bodies such as The Joint Commission, the National Committee for Quality Assurance, and/or URAC;

(d) Copies of the provider's liability insurance coverage;

(e) Copies of the provider's policies and procedures regarding seclusion and restraint practices; and

(f) Copies of the provider's Code of Conduct.(6) Reports of Review Findings:

(a) Completion Deadlines. The Division will issue a completed report of review findings, a Certificate of Approval, and any conditions to approval, or denial of approval within 60 days of the completion of an on-site review, or within 60 days of the date of submission of all review materials which have been requested for the purpose of conducting the review, whichever is later;

(b) Content and scope of reports. Reports of reviews will include the following:

(A) A description of the review findings regarding program operations relative to applicable administrative rules, and contract or agreement provisions;

(B) A specification of any conditions set as described in OAR 309-012-0200, which the provider must meet, and the time permitted to meet the conditions;

(C) A statement clarifying the provider's approval status; and

(D) An appendix containing any report of findings or observations clearly qualified as unrelated to the provider's approval status which may be useful as information and recommendations to the service provider or the CMHP.

(c) Transmittal of Reports. Each report shall be issued along with a document of transmission signed by the Assistant Administrator of the Division, and any Certificates of Approval being awarded;

(d) Report Distribution. The Division will address and issue reports as follows:

(A) Reports of reviews of a directly operated or subcontracted portion of a community mental health program will be issued to the local mental health authority;

(B) Reports of reviews of direct contractors of the Division will be issued to the signator(s) of the direct contract; and, the Chairperson of the Board of Directors of the contractor;

(C) Reports of reviews of holding facilities which are not subcontractors of a community mental health program, and reviews of non-inpatient providers will be issued to the provider's officer or employer requesting the review.

Stat. Auth.: ORS 179.040, 179.505, 426.175, 430.010, 430.640 & 743.556
Stats. Implemented: 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0200
Establishment of Conditions to the Award of Certificates of Approval

Based upon a finding that a provider does not operate in compliance with an applicable administrative rule, other than as set forth in OAR 309-012-0210(1), the Division may establish conditions to the award and/or continuation of a Certificate of Approval:

(1) Division Discretion. The Division, and, in the case of a subcontractor, the Division and CMHP, may elect to place conditions on approval of a provider in situations in which the alternative would be denial or revocation of approval because of a failure to substantially comply with applicable rules as described in OAR 309-012-0210(2). The decision to employ special conditions rather than revoke or refuse to award approval will be based on criteria such as the following:

(a) The expressed willingness of the provider to gain compliance with applicable rules;

(b) The apparent adequacy of actions proposed by the provider to gain compliance;

(c) The availability of alternative providers to address any service needs that would be unmet if the provider were not allowed conditions to approval as an alternative to revocation or refusal to award a Certificate of Approval;

(d) The provider's historical compliance with Division rules and conditions.

(2) Method of Establishment:

(a) Conditions to approval shall be communicated in writing and issued along with a document of transmission signed by the Assistant Administrator of the Office of Division;

(b) Each written condition shall specify the time period allowed to gain compliance and any interim steps for obtaining such compliance.

Stat. Auth.: ORS 179.040, 179.505, 426.175, 430.010, 430.640 & 743.556
Stats. Implemented: 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0210
Certificate Denial or Revocation

(1) Immediate Denial or Revocation. The Division, or in the case of a subcontractor provider, either the Division or the CMHP may refuse to renew or may immediately revoke a Certificate of Approval, without a prior notice or hearing when the applicant or provider:

(a) Has demonstrated substantial failure to comply with applicable rules such that the health or safety of individuals is jeopardized and the applicant fails to correct the noncompliance within the time specified by the Division;

(b) Has demonstrated a substantial failure to comply with applicable rules such that the health or safety of individuals is jeopardized during two reviews within a six-year period;

(c) Has failed to maintain any State of Oregon license which is a prerequisite for providing services that were approved;

(d) Is a county, or direct contractor that has terminated its agreement or contract with the Division for the provision of the approved services, or when the approval is to a subcontract provider of such a county or direct contractor;

(e) Is approved to provide a service as a CMHP subcontractor, whose subcontract is terminated;

(f) Continues to employ personnel who have been convicted of any felony, or a misdemeanor associated with the provision of mental health services;

(g) Falsifies information required by the Division regarding services to consumers, or information verifying compliance with rules; or

(h) Refuses to submit or allow access to information for the purpose of verifying compliance with applicable rules when notified to do so as set forth in OAR 309-012-0190(2), or fails to submit such information following the date specified for such a submission in the written notification.

(2) Denial or Revocation with Notice. Following a Division finding that there is a substantial failure to comply with applicable rules beyond the conditions in section (1) of this rule, such that, in the Division's view the state's purposes in approving the services are not or will not be met, the Division may, with 30 days notice, refuse to award or renew, or may revoke a Certificate of Approval.

(3) Informal Conference. Within ten calendar days following a 30-day notice issued under section (2) of this rule, the Division shall give the provider an opportunity for an informal conference at a location of the Division's choosing. Following such a conference, the Division may proceed with denial or revocation effective on the 30th day following the notice issued under section (2) of this rule, or may approve the provider, or set conditions to approval as described in OAR 309-012-0200 rather than denying or revoking approval.

(4) Hearing. Following issuance of a notice of Certificate revocation or denial, the Division shall provide the opportunity for a hearing as set forth in OAR 309-012-0220.

(5) A county may employ process consistent with the above, or processes adopted by resolution of the local mental health authority for revoking the approval of a subcontract provider.

Stat. Auth.: ORS 179.040, 179.505, 430.010, 430.640 743A.168, 413.032-413.033, 413.042
Stats. Implemented: 183.415, 183.430, 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 9-2015(Temp), f. & cert. ef. 11-25-15 thru 5-20-16; Administrative correction, 6-21-16; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0220
Hearings

(1) Request for Hearing. Upon written notification by the Division of revocation or denial to issue or renew a Certificate, pursuant to OAR 309-012-0210(1) and (2), the provider shall be entitled to a hearing in accordance with ORS Chapter 183. The request for hearing shall include an admission or denial of each factual matter alleged by the Division and shall affirmatively allege a short, plain statement of each relevant affirmative defense the provider may have.

(2) Hearing rights under OAR 309-012-0210(1). The immediate suspension or denial of a Certificate under OAR 309-012-0210(1) is made pending a fair hearing not later than the tenth day after such suspension or denial.

(3) Issue at hearing after immediate suspension or denial pursuant to OAR 309-012-0210(1)(a). The issue at a hearing on Certificate denial or revocation pursuant to this rule is limited to whether the provider was or is in compliance at the end of the time specified by the Division following the finding of substantial failure to comply.

Stat. Auth.: ORS 179.040, 179.505, 430.010, 430.640, 743.556 , 413.032-413.033, 413.042
Stats. Implemented: 183.430, 430.620
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92; MHS 9-2015(Temp), f. & cert. ef. 11-25-15 thru 5-20-16; Administrative correction, 6-21-16; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-012-0230
Availability of Information to Coordinated Care Organizations and Other Health Plans

Upon completion of the site review process and the issuance of a Certificate of Approval for Mental Health Services, the Division shall make copies of the following information available to Coordinated Care Organizations and other health plans for the purpose of credentialing a provider:

(1) A current program description that reflects the type and scope of behavioral health services provided by the applicant;

(2) Provider policies and procedures regarding the provider's credentialing practices of individual clinicians;

(3) Statements of provider's liability insurance coverage;

(4) An attestation from the Authority verifying that the provider has passed a screening and meets the minimum requirements to Medicaid provider;

(5) Reports detailing the findings of the Division's site review of the provider;

(6) The provider's Medicaid Vendor Identification Number issued by the Authority;

(7) Copies of the provider's policies and procedures regarding seclusion and restraint practices; and

(8) Copies of the provider's Code of Conduct.

Stat. Auth.: ORS 413.042 & 430.256
Stats. Implemented: ORS 430.01030, 430.306, 430.397, 430.405, 430.450, 430.630, 430.850, 443.400, 813.020, 813.260 & 813.500
Hist.: MHS 14-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 10-2014, f. 6-10-14, cert. ef. 6-19-14; Suspended by MHS 7-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Temporary amendments to OAR 309-039 regarding approval of providers of non-inpatient mental health treatment services.
Adm. Order No.: MHS 8-2016(Temp)
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 309-039-0500, 309-039-0510, 309-039-0530, 309-039-0580

Subject: These rules apply to certifications of provider organizations that render non-inpatient mental health treatment services. The certifications exist solely for the purpose of qualifying for insurance reimbursement. Agencies that contract with OHA, subcontract with OHA, or contract with a Community Mental Health Program are not eligible for the "non-inpatient" certification.
Rules Coordinator: Nola Russell—(503) 945-7652

309-039-0500
Purpose and Scope

These rules apply to certifications of provider organizations that render non-inpatient mental health treatment services. The certifications exist solely for the purpose of qualifying for insurance reimbursement. Agencies that contract with the Oregon Health Authority (OHA), subcontract with OHA, or contract with a Community Mental Health Program are not eligible for the "non-inpatient" certification.

Stat. Auth.: ORS 413.042 & 743A.168
Stats. Implemented: ORS 743A.160 & 743.168
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-039-0510
Definitions

As used in these rules:

(1) "Community Mental Health Program" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(2) "Certificate" means the document or documents issued by the Division, which identifies and declares certification of a provider pursuant to OAR 309-008-0100 to 309-008-1600. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

(3) "Division" means the l Health Systems Division of the Oregon Health Authority.

(4) "Facility" means a corporate or other entity which provides services for the treatment of mental health conditions.

(5) "Non-Related Adult" means any person over 18 years of age who is not related by blood, marriage or living situation. Foster parents and adults co-habitating with a child may be considered to be related adults.

(6) "Outpatient Program" means a program that provides evaluation, treatment and rehabilitation on a regularly scheduled basis or in response to crisis in a setting outside an inpatient program, residential program, day treatment or partial hospitalization program which is certified by the Division pursuant to OAR to 309-008-1600.

(7) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(8) "Provider" means a program operated by either a licensed business or a corporation that provides mental health services.

(9) "Qualified Mental Health Associate (QMHA)" means a person delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-019-0125(7).

(10) "Qualified Mental Health Professional (QMHP)" means a LMP or any other person meeting the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-019-0125(8).

(11) "Qualified Supervisor" means any person meeting the following qualifications:

(a) A medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon and who is board eligible for the practice of psychiatry;

(b) A psychologist licensed by the State Board of Psychologist Examiners;

(c) A registered nurse certified as a psychiatric nurse practitioner by the Oregon State Board of Nursing;

(d) A clinical social worker licensed by the State Board of Clinical Social Workers;

(e) A Licensed Professional Counselor (LPC) licensed by the State of Oregon; or

(f) A Licensed Marriage and Family Therapist (LMFT), licensed by the State of Oregon.

(12) "Residential Program" means a program that provides room, board, and an organized full-day program of mental health services in a facility for six or more persons who do not require 24-hour nursing care.

Stat. Auth.: ORS 413.042 & 743A.168
Stats. Implemented: ORS 743A.160 & 743.168
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-039-0530
Approval Process

(1) Request for initial certification or certification renewal shall be submitted to the Division compliant with the process governed by OAR 309-0080100 to 309-008-1600. In addition to the requirements set in OAR 309-008 the applicant will include with the application a check or money order in the amount of $600.00 payable to the Division. This application fee shall be non-refundable irrespective of whether the provider is issued a Certificate of Approval.

(a) Any provider submitting an application for initial certification or renewal after the effective date of this rule shall pay the application and certification fees;

(b) The fees shall be increased biennially at the same rate as approved by the Legislative Assembly or the Emergency Board for other services and programs of the Division.

(2) A Certificate is valid for up to three years, shall be issued to the provider when the administrative and certification reviews of the program by the Division indicate the provider is in compliance with the applicable parts of OAR 309-039-0500 through 309-039-0580. The Certificate will be issued pursuant to the process governed OAR 309-008-0100 to 309-008-1600.

(4) The award, renewal, and duration of Certificates of Approval as well as periodic and interim reviews, establishment of conditions, denial, revocation and hearings shall comply with OAR 309-008-0100 to 309-008-1600.

Stat. Auth.: ORS 413.042 & 743A.168
Stats. Implemented: ORS 743A.160 & 743.168
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 13-2013(Temp), f. & cert. ef. 12-20-13 thru 6-18-14; MHS 11-2014, f. 6-17-14, cert. ef. 6-19-14; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-039-0580
Variance

A variance to these rules may be requested and granted to a provider via the process governed by OAR 309-008-1600.

Stat. Auth.: ORS 413.042 & 743A.168
Stats. Implemented: ORS 743A.160 & 743.168
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93; MHS 8-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Temporary amendments to OAR 309-022 regarding intensive treatment for Children and Childrens' Emergency Safety Intervention.
Adm. Order No.: MHS 9-2016(Temp)
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Amended: 309-022-0100, 309-022-0105, 309-022-0135, 309-022-0175, 309-022-0205
Subject: (1) Purpose: These rules prescribe minimum standards for services and supports provided by addictions and mental health providers approved by the Health System Division of the Oregon Health Authority.

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for services and supports provided in: Intensive Treatment Services (ITS) for Children and Adolescents.
Rules Coordinator: Nola Russell—(503) 945-7652

309-022-0100
Purpose and Scope

(1) Purpose: These rules prescribe minimum standards for services and supports provided by addictions and mental health providers approved

by the Health Systems Division (HSD) of the Oregon Health Authority (OHA).

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for services and supports provided in: Intensive Treatment Services (ITS) for Children and Adolescents.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-022-0105
Definitions

(1) "Abuse of a child" means the circumstances defined in ORS 419B.005.

(2) "Health Systems Services and Supports" means all services and supports including but not limited to, Outpatient Community Mental Health Services and Supports for Children and Adults, Intensive Treatment Services for Children, Outpatient and Residential Substance Use Disorders Treatment Services and Outpatient and Residential Problem Gambling Treatment Services.

(3) "Adolescent" means an individual from 12 through 17 years of age, or those individuals who are determined to be developmentally appropriate for youth services.

(4) "Assessment" means the process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.

(5) "Authority" means the Oregon Health Authority.

(6) "Behavioral Health" means mental health, mental illness, addictive health and addiction disorders.

(7) "Behavior Support Plan" means the individualized proactive support strategies that are used to support positive behavior.

(8) "Behavior Support Strategies" means proactive supports designed to replace challenging behavior with functional, positive behavior. The strategies address environmental, social, neuro-developmental and physical factors that affect behavior.

(9) "Care Coordination" means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.

(10) "Certificate" means the document or documents issued by the Division, which identifies and declares certification of a provider pursuant to OAR 309-008-0100 to 309-008-1600. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

(11) "Chemical Restraint" means the administration of medication for the acute management of potentially harmful behavior. Chemical restraint is prohibited in the services regulated by these rules.

(12) "Chief Officer" means the Chief Health Systems Officer of the Oregon Health Authority, or his or her designee.

(13) "Child" means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.

(14) "Child and Family Team" means those persons who are responsible for creating, implementing, reviewing, and revising the service coordination section of the Service Plan in ICTS programs. At a minimum, the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family.

(15) "Children's Emergency Safety Intervention Specialist (CESIS)" means a Qualified Mental Health Professional (QMHP) who is licensed to order, monitor, and evaluate the use of seclusion and restraint in accredited and certified facilities providing intensive mental health treatment services to individuals less than 21 years of age.

(16) "Clinical Supervision" means oversight by a qualified Clinical Supervisor of addictions and mental health services and supports provided according to this rule, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(17) "Clinical Supervisor" means a person qualified to oversee and evaluate addictions or mental health services and supports.

(18) "Community Mental Health Program" (CMHP) means an entity that is responsible for planning and delivery of services for individuals with substance use or mental illness diagnoses, operated in a specific geographic area of the state under an intergovernmental agreement or a direct contract with the Addictions and Mental Health Division (AMH).

(19) "Co-occurring Disorder" means the existence of both, a substance use disorder and also mental health disorder.

(20) "Coordinated Care Organization (CCO)" means an entity that has been certified by the Authority to provide coordinated and integrated health services.is a network of all types of health care providers (physical health care, addictions and mental health care and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

(21) "Community Mental Health Program (CMHP)" means an entity that is responsible for planning and delivery of services for persons with substance use disorders or a mental health diagnosis, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(22) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.

(23) "Crisis" means either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care.

(24) "Cultural Competence" means the process by which people and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

(25) "Declaration for Mental Health Treatment" means a written statement of an individual's preferences concerning his or her mental health treatment. The declaration is made when the individual is able to understand and legally make decisions related to such treatment. It is honored, as clinically appropriate, in the event the individual becomes unable to make such decisions.

(26) "Diagnosis" means the principal mental health, substance use or problem gambling diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the assessment and any examinations, tests, or consultations suggested by the assessment, and are the medically appropriate reason for services.

(27) "Division" means the Health Systems Division.

(28) "DSM" means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(29) "Emergency Safety Intervention" means the use of seclusion or personal restraint under OAR 309-021-0175 of these rules, as an immediate response to an unanticipated threat of violence or injury to an individual, or others.

(30) "Emergency Safety Intervention Training" means a Division approved course that includes an identified instructor, a specific number of face-to-face instruction hours, a component to assess competency of the course materials, and an established curriculum including the following:

(a) Prevention of emergency safety situations using positive behavior support strategies identified in the individual's behavior support plan;

(b) Strategies to safely manage emergency safety situations; and

(c) De-escalation and debriefing.

(31) "Emergency Safety Situation" means an unanticipated behavior that places the individual or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

(32) "Emergent" means the onset of symptoms requiring attention within 24 hours to prevent serious deterioration in mental or physical health or threat to safety.

(33) "Entry" means the act or process of acceptance and enrollment into services regulated by this rule.

(34) "Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adop-

tion, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

(35) "Family Support" means the provision of supportive services to persons defined as family to the individual. It includes support to caregivers at community meetings, assistance to families in system navigation and managing multiple appointments, supportive home visits, peer support, parent mentoring and coaching, advocacy, and furthering efforts to develop natural and informal community supports.

(36) "Gender Identity" means a person's self-identification of gender, without regard to legal or biological identification, including, but not limited to persons identifying themselves as male, female, transgender and transsexual.

(37) "Gender Presentation" means the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns and social interactions.

(38) "Grievance" means a formal complaint submitted to a provider verbally, or in writing, by an individual, or the individual's chosen representative, pertaining to the denial or delivery of services and supports.

(39) "Guardian" means a person appointed by a court of law to act as guardian of a minor or a legally incapacitated person.

(40) "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

(41) "Individual" means any person being considered for or receiving services and supports regulated by these rules.

(42) "Informed Consent for Services" means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the individual and guardian, if applicable, have consented to the services on, or prior to, the first date of service.

(43) "Intensive Community-based Treatment and Support Services (ICTS)" means a specialized set of comprehensive in-home and community-based supports and mental health treatment services, including care coordination as defined in these rules, for children that are developed by the child and family team and delivered in the most integrated setting in the community.

(44) "Intensive Treatment Services (ITS)" means the range of services in the system of care comprised of Psychiatric Residential Treatment Facilities (PRTF) and Psychiatric Day Treatment Services (PDTS), or other services as determined by the Division, that provide active psychiatric treatment for children with severe emotional disorders and their families.

(45) "Interdisciplinary Team" means the group of people designated to advise in the planning and provision of services and supports to individuals receiving ITS services and may include multiple disciplines or agencies. For Psychiatric Residential Treatment Facilities (PRTF), the composition of the interdisciplinary team must be consistent with the requirements of 42 CFR Part 441.156.

(46) "Intern" or "Student" means a person who provides a paid or unpaid program service to complete a credentialed or accredited educational program recognized by the state of Oregon.

(47) "Juvenile Psychiatric Security Review Board (JPSRB)" means the entity described in ORS 161.385.

(48) "Level of Care" means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

(49) "Level of Service Intensity Determination." means the Division approved process by which children and young adults in transition are assessed for ITS and ICTS services.

(50) "Licensed Health Care Professional" means a practitioner of the healing arts, acting within the scope of his or her practice under State law, who is licensed by a recognized governing board in Oregon.

(51) "Licensed Medical Practitioner (LMP)" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Physician licensed to practice in the State of Oregon; or

(b) Nurse practitioner licensed to practice in the State of Oregon; or

(c) Physician's Assistant licensed to practice in the State of Oregon; and

(d) Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management.

(e) For ICTS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(52) "Local Mental Health Authority (LMHA)" means one of the following entities:

(a) The board of county commissioners of one or more counties that establishes or operates a CMHP;

(b) The tribal council, in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or

(c) A regional local mental health authority comprised of two or more boards of county commissioners.

(53) "Mandatory Reporter" means any public or private official, as defined in ORS 419B.005(3), who comes in contact with or has reasonable cause to believe that an individual has suffered abuse, or that any person with whom the official comes in contact with, has abused the individual. Pursuant to 430.765(2) psychiatrists, psychologists, clergy and attorneys are not mandatory reporters with regard to information received through communications that are privileged under 40.225 to 40.295.

(54) "Mechanical restraint" means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. Mechanical restraint is prohibited in the services regulated by these rules.

(55) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to eligible persons, under Title XIX of the Social Security Act. (56) "Medical Supervision" means an LMP's review and approval, at least annually, of the medical appropriateness of services and supports identified in the Service Plan for each individual receiving mental health services for one or more continuous years.

(56) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis or treatment of a physical or behavioral health condition, 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 and professional standards of care as effective;

(c) Not solely for the convenience of an individual 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 an individual.

(57) "Mental Health Intern" means a person who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work or behavioral science field to meet the educational requirement of QMHP. The person must:

(a) Be currently enrolled in a graduate program for a master's degree in psychology, social work or in a behavioral science field;

(b) Have a collaborative educational agreement with the CMHP, or other provider, and the graduate program;

(c) Work within the scope of his/her practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by provider; and

(d) Receive, at minimum, weekly supervision by a qualified clinical supervisor employed by the provider of services.

(58) "Mental Health Organization (MHO)" means an approved organization that provides most mental health services through a capitated payment mechanism under the Oregon Health Plan. MHOs may be fully capitated health plans, community mental health programs, private mental health organizations or combinations thereof.

(59) "Oregon Health Authority" means the Oregon Health Authority of the State of Oregon.

(60) "Outreach" means the delivery of behavioral health services, referral services and case management services in non-traditional settings, such as, but not limited to, the individual's residence, shelters, streets, jails, transitional housing sites, drop-in centers, single room occupancy hotels, child welfare settings, educational settings or medical settings. It also refers to attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.

(61) "Peer" means any person supporting an individual, or a family member of an individual, who has similar life experience, either as a current or former recipient of addictions or mental health services, or as a family member of an individual who is a current or former recipient of addictions or mental health services.

(62) "Peer Delivered Services" means an array of agency or community-based services and supports provided by peers, and peer support specialists, to individuals or family members with similar lived experience, that are designed to support the needs of individuals and families as applicable.

(63) "Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete a Division approved training program as required in OAR 410-180-0300 to 0380 and be:

(a) A self-identified person currently or formerly receiving mental health services; or

(b) A self-identified person in recovery from a substance use or gambling disorder, who meets the abstinence requirements for recovering staff in substance use disorders or gambling treatment programs; or

(c) A family member of an individual who is a current or former recipient of addictions or mental health services.

(64) "Personal Restraint" means the application of physical force without the use of any device, for the purpose of restraining the free movement of an individual's body to protect the individual, or others, from immediate harm. Personal restraint does not include briefly holding without undue force an individual to calm or comfort him or her, or holding an individual's hand to safely escort him or her from one area to another. Personal restraint can be used only in approved ITS programs as an emergency safety intervention under OAR 309-021-0175.

(65) "Program" means a particular type or level of service that is organizationally distinct.

(66) "Program Administrator" or "Program Director" means a person with appropriate professional qualifications and experience, who is designated to manage the operation of a program.

(67) "Program Staff" means an employee or person who, by contract with the program, provides a service and who has the applicable competencies, qualifications or certification, required in this rule to provide the service.

(68) "Provider" means an organizational entity, or qualified person, that is operated by or contractually affiliated with, a community mental health program, or contracted directly with the Division, for the direct delivery of addictions, problem gambling or mental health services and supports.

(69) "Psychiatrist" means a physician licensed pursuant to ORS 677.010 to 677.228 and 677.410 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(70) "Psychiatric Day Treatment Services (PDTS)" means the comprehensive, interdisciplinary, non-residential, community-based program certified under this rule consisting of psychiatric treatment, family treatment and therapeutic activities integrated with an accredited education program.

(71) "Psychiatric Residential Treatment Facility (PRTF)" means facilities that are structured residential treatment environments with daily 24-hour supervision and active psychiatric treatment including Psychiatric Residential Treatment Services (PRTS), Secure Children's Inpatient Treatment Programs (SCIP), Secure Adolescent Inpatient Treatment Programs (SAIP), and Sub-acute psychiatric treatment for children who require active treatment for a diagnosed mental health condition in a 24-hour residential setting.

(72) "Psychiatric Residential Treatment Services (PRTS)" means services delivered in a PRTF that include 24-hour supervision for children who have serious psychiatric, emotional or acute mental health conditions that require intensive therapeutic counseling and activity and intensive staff supervision, support and assistance.

(73) "Psychologist" means a psychologist licensed by the Oregon Board of Psychologist Examiners.

(74) "Publicly Funded" means financial support, in part or in full, with revenue generated by a local, state or federal government.

(75) "Qualified Mental Health Associate (QMHA)" means a person delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-022-0125.

(76) "Qualified Mental Health Professional (QMHP)" means a LMP or any other person meeting the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-022-0125.

(77) "Quality Assessment and Performance Improvement" means the structured, internal monitoring and evaluation of services to improve processes, service delivery and service outcomes.

(78) "Recovery" means a process of healing and transformation for a person to achieve full human potential and personhood in leading a meaningful life in communities of his or her choice.

(79) "Reportable Incident" means a serious incident involving an individual in an ITS program that must be reported in writing to the Division within 24 hours of the incident, including, but not limited to, serious injury or illness, act of physical aggression that results in injury, suspected abuse or neglect, involvement of law enforcement or emergency services, or any other serious incident that presents a risk to health and safety.

(80) "Representative" means a person who acts on behalf of an individual, at the individual's request, with respect to a grievance, including, but not limited to a relative, friend, employee of the Division, attorney or legal guardian.

(81) "Resilience" means the universal capacity that a person uses to prevent, minimize, or overcome the effects of adversity. Resilience reflects a person's strengths as protective factors and assets for positive development.

(82) "Respite care" means planned and emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. Respite care can be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the Service Plan.

(83) "Screening" means the process to determine whether the individual needs further assessment to identify circumstances requiring referrals or additional services and supports.

(84) "Seclusion" means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving. Seclusion can be used only in approved ITS programs as an emergency safety intervention specified in OAR 309-022-0175.

(85) "Secure Children's Inpatient Programs (SCIP) and Secure Adolescent Inpatient Programs (SAIP)" means ITS programs that are designed to provide inpatient psychiatric stabilization and treatment services to children up to age 14 for SCIP services and individuals under the age of 21 for SAIP services, who require a secure intensive treatment setting.

(86) "Service Plan" means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service.

(87) "Service Note" means the written record of services and supports provided, including documentation of progress toward intended outcomes, consistent with the timelines stated in the Service Plan.

(88) "Service Record" means the documentation, written or electronic, regarding an individual and resulting from entry, assessment, orientation, services and supports planning, services and supports provided, and transfer.

(89) "Services" means those activities and treatments described in the Service Plan that are intended to assist the individual's transition to recovery from a substance use disorder, problem gambling disorder or mental health condition, and to promote resiliency, and rehabilitative and functional individual and family outcomes.

(90) "Signature" means any written or electronic means of entering the name, date of authentication and credentials of the person providing a specific service or the person authorizing services and supports. Signature also means any written or electronic means of entering the name and date of authentication of the individual receiving services, the guardian of the individual receiving services, or any authorized representative of the individual receiving services.

(91) "Skills Training" means providing information and training to individuals and families designed to assist with the development of skills in areas including, but not limited to, anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, symptom management, accessing community services and daily living.

(92) "Sub-Acute Psychiatric Care" means services that are provided by nationally accredited providers to children who need 24-hour intensive mental health services and supports, provided in a secure setting to assess, evaluate, stabilize or resolve the symptoms of an acute episode that occurred as the result of a diagnosed mental health condition.

(93) "Supports" means activities, referrals and supportive relationships designed to enhance the services delivered to individuals and families for the purpose of facilitating progress toward intended outcomes.

(94) "Transfer" means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.

(95) "Trauma Informed Services" means services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health and addictions services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and are delivered in a

way that avoids inadvertent re-traumatization and facilitates individual direction of services.

(96) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis, that are included in the Service Plan.

(97) "Urgent" means the onset of symptoms requiring attention within 48 hours to prevent a serious deterioration in an individual's mental or physical health or threat to safety.

(98) "Variance" means an exception from a provision of these rules, granted in writing by the Division, upon written application from the provider. Duration of a variance is determined on a case-by-case basis.

(99) "Volunteer" means an individual who provides a program service or who takes part in a program service and who is not an employee of the program and is not paid for services. The services must be non-clinical unless the individual has the required credentials to provide a clinical service.

(100) "Wellness" means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.

(101) "Young Adult in Transition" means an individual who is developmentally transitioning into independence, sometime between the ages of 14 and 25.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-022-0135
Entry and Assessment

(1) Entry Process: The program must utilize a written entry procedure to ensure the following:

(a) Individuals must be considered for entry without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, except when program eligibility is restricted to children, adults or older adults, familial status, marital status, source of income, and disability.

(b) Individuals must receive services in the most timely manner feasible consistent with the presenting circumstances.

(c) Written informed consent for services must be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason must be documented and further attempts to obtain informed consent must be made as appropriate.

(d) The provider must establish a Service Record for each individual on the date of entry.

(e) The provider must report the entry of all individuals on the mandated state data system.

(f) In accordance with ORS 179.505 and HIPAA, an authorization for the release of information must be obtained for any confidential information concerning the individual being considered for, or receiving, services.

(2) Orientation: At the time of entry, the program must offer to the individual and guardian if applicable, written program orientation information. The written information must be in a language understood by the individual and must include:

(a) A description of individual rights consistent with these rules; and

(b) Policies concerning grievances and confidentiality.

(3) Entry of children in community-based mental health services, whose services are not funded by Medicaid, must be prioritized in the following order:

(a) Children who are at immediate risk of psychiatric hospitalization or removal from home due to emotional and mental health conditions;

(b) Children who have severe mental health conditions;

(c) Children who exhibit behavior which indicates high risk of developing conditions of a severe or persistent nature; and

(d) Any other child who is experiencing mental health conditions which significantly affect the child's ability to function in everyday life but not requiring hospitalization or removal from home in the near future.

(4) Assessment:

(a) At the time of entry, an assessment must be completed prior to development of the Service Plan.

(b) The assessment must be completed by a QMHP. A QMHA may assist in the gathering and compiling of information to be included in the assessment.

(c) Each assessment must include:

(A) Sufficient information and documentation to justify the presence of a DSM diagnosis that is the medically appropriate reason for services.

(B) Suicide potential must be assessed and Service Records must contain follow-up actions and referrals when an individual reports symptoms indicating risk of suicide;

(C) Screening for the presence of co-occurring disorders and chronic medical conditions; and

(D) Screening for the presence of symptoms related to physical or psychological trauma.

(d) When the assessment process determines the presence of co-occurring disorders, providers must document referral for further assessment, planning and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(e) In addition to periodic assessment updates based on changes in the clinical circumstance, any individual continuing to receive mental health services for one or more continuous years, must receive an annual assessment by a LMP.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-022-0175
Restraint and Seclusion

(1) Providers must meet the following general conditions of personal restraint and seclusion:

(a) Personal restraint and seclusion must only be used in an emergency safety situation to prevent immediate injury to an individual who is in danger of physically harming him or herself or others in situations such as the occurrence of, or serious threat of violence, personal injury or attempted suicide;

(b) Any use of personal restraint or seclusion must respect the dignity and civil rights of the individual;

(c) The use of personal restraint or seclusion must be directly related to the immediate risk related to the behavior of the individual and must not be used as punishment, discipline, or for the convenience of staff;

(d) Personal restraint or seclusion must only be used for the length of time necessary for the individual to resume self-control and prevent harm to the individual or others, even if the order for seclusion or personal restraint has not expired, and must under no circumstances, exceed 4 hours for individuals ages 18 to 21, 2 hours for individuals ages 9 to 17, or 1 hour for individuals under age 9;

(e) An order for personal restraint or seclusion must not be written as a standing order or on an as needed basis;

(f) Personal restraint and seclusion must not be used simultaneously;

(g) Providers must notify the individual's parent or guardian of any incident of seclusion or personal restraint as soon as possible;

(h) If incidents of personal restraint or seclusion used with an individual cumulatively exceed five interventions over a period of five days, or a single episode of one hour within 24 hours, the psychiatrist, or designee, must convene, by phone or in person, program staff with designated clinical leadership responsibilities to:

(A) Discuss the emergency safety situation that required the intervention, including the precipitating factors that led up to the intervention and any alternative strategies that might have prevented the use of the personal restraint or seclusion;

(B) Discuss the procedures, if any, to be implemented to prevent any recurrence of the use of personal restraint or seclusion;

(C) Discuss the outcome of the intervention including any injuries that may have resulted; and

(D) Review the individual's Service Plan, making the necessary revisions, and document the discussion and any resulting changes to the individual's Service Plan in the Service Record.

(2) Personal Restraint:

(a) Each personal restraint must require an immediate documented order by a physician, licensed practitioner, or, in accordance with OAR 309-034-0400 through 309-034-0490, a licensed CESIS;

(b) The order must include:

(A) Name of the person authorized to order the personal restraint;

(B) Date and time the order was obtained; and

(C) Length of time for which the intervention was authorized.

(c) Each personal restraint must be conducted by program staff that have completed and use Division-approved crisis intervention training. If in the event of an emergency a non-Division approved crisis intervention

technique is used, the provider's on-call administrator must immediately review the intervention and document the review in an incident report to be provided to the Division within 24 hours;

(d) At least one program staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the individual and the safe use of the personal restraint throughout the duration of the personal restraint;

(e) Within one hour of the initiation of a personal restraint, a psychiatrist, licensed practitioner, or CESIS must conduct a face-to-face assessment of the physical and psychological well-being of the individual;

(f) A designated program staff with clinical leadership responsibilities must review all personal restraint documentation prior to the end of the shift in which the intervention occurred; and

(g) Each incident of personal restraint must be documented in the Service Record. The documentation must specify:

(A) Behavior support strategies and less restrictive interventions attempted prior to the personal restraint;

(B) Required authorization;

(C) Events precipitating the personal restraint;

(D) Length of time the personal restraint was used;

(E) Assessment of appropriateness of the personal restraint based on threat of harm to self or others;

(F) Assessment of physical injury; and

(G) Individuals response to the emergency safety intervention.

(3) Seclusion: Providers must be certified by the Division for the use of seclusion.

(a) Authorization for seclusion must be obtained by a psychiatrist, licensed practitioner or CESIS prior to, or immediately after the initiation of seclusion. Written orders for seclusion must be completed for each instance of seclusion and must include:

(A) Name of the person authorized to order seclusion;

(B) Date and time the order was obtained; and

(C) Length of time for which the intervention was authorized.

(b) Program staff trained in the use of emergency safety interventions must be physically present continually assessing and monitoring the physical and psychological well-being of the individual throughout the duration of the seclusion;

(c) Visual monitoring of the individual in seclusion must occur continuously and be documented at least every fifteen minutes or more often as clinically indicated;

(d) Within one hour of the initiation of seclusion a psychiatrist or CESIS must conduct a face-to-face assessment of the physical and psychological well-being of the individual;

(e) The individual must have regular meals, bathing, and use of the bathroom during seclusion and the provision of these must be documented in the Service Record; and

(f) Each incident of seclusion must be documented in the Service Record. The documentation must specify:

(A) The behavior support strategies and less restrictive interventions attempted prior to the use of seclusion;

(B) The required authorization for the use of seclusion;

(C) The events precipitating the use of seclusion;

(D) The length of time seclusion was used;

(E) An assessment of the appropriateness of seclusion based on threat of harm to self or others;

(F) An assessment of physical injury to the individual, if any; and

(G) The individual's response to the emergency safety intervention.

(4) Any room specifically designated for the use of seclusion or time out must be approved by the Division.

(a) If the use of seclusion occurs in a room with a locking door, the program must be authorized by the Division for this purpose and must meet the following requirements:

(A) A facility or program seeking authorization for the use of seclusion must submit a written application to the Division;

(B) Application must include a comprehensive plan for the need for and use of seclusion of children in the program and copies of the facility's policies and procedures for the utilization and monitoring of seclusion including a statistical analysis of the facility's actual use of seclusion, physical space, staff training, staff authorization, record keeping and quality assessment practices;

(C) The Division must review the application and, after a determination that the written application is complete and satisfies all applicable requirements, must provide for a review of the facility by authorized Division staff;

(D) The Division must have access to all records including Service Records, the physical plant of the facility, the employees of the facility, the professional credentials and training records for all program staff, and must have the opportunity to fully observe the treatment and seclusion practices employed by the facility;

(E) After the review, the Chief Officer must approve or disapprove the facility's application and upon approval must certify the facility based on the determination of the facility's compliance with all applicable requirements for the seclusion of children;

(F) If disapproved, the facility must be provided with specific recommendations and have the right of appeal to the Division; and

(G) Certification of a facility must be effective for a maximum of three years and may be renewed thereafter upon approval of a renewal application.

(5) Structural and physical requirements for seclusion: An ITS provider seeking this certification under these rules must have available at least one room that meets the following specifications and requirements:

(a) The room must be of adequate size to permit three adults to move freely and allows for one adult to lie down. Any newly constructed room must be no less than 64 square feet;

(b) The room must not be isolated from regular program staff of the facility, and must be equipped with adequate locking devices on all doors and windows;

(c) The door must open outward and contain a port of shatterproof glass or plastic through which the entire room may be viewed from outside;

(d) The room must contain no protruding, exposed, or sharp objects;

(e) The room must contain no furniture. A fireproof mattress or mat must be available for comfort;

(f) Any windows must be made of unbreakable or shatterproof glass or plastic. Non-shatterproof glass must be protected by adequate climb-proof screening;

(g) There must be no exposed pipes or electrical wiring in the room. Electrical outlets must be permanently capped or covered with a metal shield secured by tamper-proof screws. Ceiling and wall lights must be recessed and covered with safety glass or unbreakable plastic. Any cover, cap or shield must be secured by tamper-proof screws;

(h) The room must meet State Fire Marshal fire, safety, and health standards. If sprinklers are installed, they must be recessed and covered with fine mesh screening. If pop-down type, sprinklers must have break-away strength of under 80 pounds. In lieu of sprinklers, combined smoke and heat detector must be used with similar protective design or installation;

(i) The room must be ventilated, kept at a temperature no less than 64°F and no more than 85°F. Heating and cooling vents must be secure and out of reach;

(j) The room must be designed and equipped in a manner that would not allow a child to climb off the ground;

(k) Walls, floor and ceiling must be solidly and smoothly constructed, to be cleaned easily, and have no rough or jagged portions; and

(l) Adequate and safe bathrooms must be available.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 28.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168

Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

309-022-0205

CESIS License Applications

(1) Application for licensure as a CESIS shall be made to the Division and be on forms prescribed by the Division.

(2) Application for licensure shall be accompanied by a formal written request from a provider that is certified by the Division, pursuant to OAR 309-008-0100 to 309-008-1600, to provide intensive mental health treatment services for individuals under 21 years of age with which the applicant is employed or contracted. The request must include:

(a) Official transcripts and supporting documentation as necessary showing the applicant meets qualifications established by rule for a QMHP;

(b) Verification that an emergency safety intervention course approved by the Division has been successfully completed within the past 12 months;

(c) Verification of certification in CPR and First Aid by a recognized training agency;

(d) A signed Background Check Request form as described in OAR chapter 943 division 007. The Criminal Record Check form will request information regarding criminal history and other information;

(e) Verification of employment or contracted services with a provider that is certified by the Division to provide intensive mental health treatment services for individuals under 21 years of age;

(f) A copy of the completed examination or evaluation the provider used to determine the applicant's competence to assess the psychological and physical well-being of individuals under 21 years of age; and

(g) A copy of the completed examination or evaluation the provider used to determine the applicants knowledge of the federal and state rules governing the use of seclusion and personal restraint in intensive mental health treatment programs for individuals less than 21 years of age.

Stat. Auth.: ORS 413.042 & 426.415
Stats. Implemented: ORS 426.415
Hist.: MHS 8-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 5-2014, f. & cert. ef. 2-3-14; MHS 9-2016(Temp), f. 6-28-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Temporary amendments to 309-018 titled "Residential Substance Use and Problem Gambling Treatment and Recovery Services".
Adm. Order No.: MHS 10-2016(Temp)
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Adopted: 309-018-0107
Rules Amended: 309-018-0100, 309-018-0105, 309-018-0160, 309-018-0210, 309-018-0215
Subject: (1) Purpose: These rules prescribe minimum standards for services and supports provided by addictions and mental health providers approved by the Addictions and Mental Health Systems Division of the Oregon Health Authority.

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for services and supports provided in:

(a) Residential Substance Use Disorders Treatment and Recovery Services; and

(b) Residential Problem Gambling Treatment and Recovery Services.
Rules Coordinator: Nola Russell—(503) 945-7652

309-018-0100
Purpose and Scope

(1) Purpose: These rules prescribe minimum standards for services and supports provided by addictions and mental health providers approved by the Health Systems Division of the Oregon Health Authority.

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for services and supports provided in:

(a) Residential Substance Use Disorders Treatment and Recovery Services; and

(b) Residential Problem Gambling Treatment and Recovery Services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0105
Definitions

(1) "Abuse of an adult" means the circumstances defined in OAR 407-045-0260 for abuse of an adult with mental illness.

(2) "Abuse of a child" means the circumstances defined in ORS 419B.005.

(3) " Health Systems Services and Supports" means all services and supports including but not limited to, Outpatient Community Mental Health Services and Supports for Children and Adults, Intensive Treatment Services for Children, Outpatient and Residential Substance Use Disorders Treatment Services and Outpatient and Residential Problem Gambling Treatment Services.

(4) "Adolescent" means an individual from 12 through 17 years of age, or those individuals who are determined to be developmentally appropriate for youth services.

(5) "Adult" means a person 18 years of age or older, or an emancipated minor. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.

(6) "Assessment" means the process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.

(7) "ASAM PPC" means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care, and incorporated by reference in these rules.

(8) "Authority" means the Oregon Health Authority.

(9) "Behavioral Health" means mental health, mental illness, addictive health and addiction disorders.

(10) "Case Management" means the services provided to assist individuals, who reside in a community setting, or are transitioning to a community setting, in gaining access to needed medical, social, educational, entitlement and other applicable services.

(11) "Certificate" means the document or documents issued by the Division, which identifies and declares certification of a provider pursuant to OAR 309-008-0100 to 309-008-1600. A letter accompanying issuance of the certificate will detail the scope and approved service delivery locations of the certificate.

(12) "Child" means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.

(13) "Chief Officer" means the Chief Health Systems Officer of the Health Systems Division, or his or her designee.

(14) "Clinical Supervision" means oversight by a qualified Clinical Supervisor of addictions and mental health services and supports provided according to this rule, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(15) "Clinical Supervisor" means a person qualified to oversee and evaluate addictions or mental health services and supports.

(16) "Co-occurring substance use and mental health disorders (COD)" means the existence of a diagnosis of both a substance use disorder and a mental health disorder.

(17) "Court" means the last convicting or ruling court unless specifically noted.

(18) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.

(19) "Crisis" means either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care.

(20) "Cultural Competence" means the process by which people and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

(21) "Culturally Specific Program" means a program that is designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture.

(22) "Diagnosis" means the principal mental health, substance use or problem gambling diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the assessment and any examinations, tests, or consultations suggested by the assessment, and are the medically appropriate reason for services.

(23) "Division" means the Health Systems Division.

(24) "DSM" means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(25) "Emergent" means the onset of symptoms requiring attention within 24 hours to prevent serious deterioration in mental or physical health or threat to safety.

(26) "Entry" means the act or process of acceptance and enrollment into services regulated by this rule.

(27) "Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adop-

tion, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

(28) "Gender Identity" means a person's self-identification of gender, without regard to legal or biological identification, including, but not limited to persons identifying themselves as male, female, transgender and transsexual.

(29) "Gender Presentation" means the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns and social interactions.

(30) "Grievance" means a formal complaint submitted to a provider verbally, or in writing, by an individual, or the individual's chosen representative, pertaining to the denial or delivery of services and supports.

(31) "Guardian" means a person appointed by a court of law to act as guardian of a minor or a legally incapacitated person.

(32) "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

(33) "Incident Report" means a written description of any incident involving an individual, or child of an individual receiving services, occurring on the premises of the program, or involving program staff or a Service Plan activity including, but not limited to, injury, major illness, accident, act of physical aggression, medication error, suspected abuse or neglect, or any other unusual incident that presents a risk to health and safety.

(34) "Individual" means any person being considered for or receiving services and supports regulated by these rules.

(35) "Informed Consent for Services" means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the individual and guardian, if applicable, have consented to the services on, or prior to, the first date of service.

(36) "Interim Referral and Information Services" means services provided by an substance use disorders treatment provider to individuals on a waiting list, and whose services are funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, to reduce the adverse health effects of substance use, promote the health of the individual and reduce the risk of disease transmission.

(37) "Intern" or "Student" means a person who provides a paid or unpaid program service to complete a credentialed or accredited educational program recognized by the state of Oregon.

(38) "Level of Care" means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

(39) "Licensed Health Care Professional" means a practitioner of the healing arts, acting within the scope of his or her practice under State law, who is licensed by a recognized governing board in Oregon.

(40) "Licensed Medical Practitioner (LMP)" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Physician licensed to practice in the State of Oregon; or

(b) Nurse practitioner licensed to practice in the State of Oregon; or

(c) Physician's Assistant licensed to practice in the State of Oregon; and

(d) Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management.

(41) "Local Mental Health Authority (LMHA)" means one of the following entities:

(a) The board of county commissioners of one or more counties that establishes or operates a CMHP;

(b) The tribal council, in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or

(c) A regional local mental health authority comprised of two or more boards of county commissioners.

(42) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to eligible persons, under Title XIX of the Social Security Act.

(43) "Medical Director" means a physician licensed to practice medicine in the State of Oregon and who is designated by a substance use disorders treatment program to be responsible for the program's medical services, either as an employee or through a contract.

(44) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis or treatment of a physical or behavioral health condition, 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 and professional standards of care as effective;

(c) Not solely for the convenience of an individual 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 an individual.

(45) "Medication Administration Record" means the documentation of the administration of written or verbal orders for medication, laboratory and other medical procedures issued by a LMP acting within the scope of his or her license.

(46) "Oregon Health Authority" means the Oregon Health Authority of the State of Oregon.

(47) "Outreach" means the delivery of behavioral health services, referral services and case management services in non-traditional settings, such as, but not limited to, the individual's residence, shelters, streets, jails, transitional housing sites, drop-in centers, single room occupancy hotels, child welfare settings, educational settings or medical settings. It also refers to attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.

(48) "Peer" means any person supporting an individual, or a family member of an individual, who has similar life experience, either as a current or former recipient of addictions or mental health services, or as a family member of an individual who is a current or former recipient of addictions or mental health services.

(49) "Peer Delivered Services" means an array of agency or community-based services and supports provided by peers, and peer support specialists, to individuals or family members with similar lived experience, that are designed to support the needs of individuals and families as applicable.

(50) "Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete a Division approved training program as required by OAR 410-180-0300 through 410-180-0300 and be:

(a) A self-identified person currently or formerly receiving mental health services; or

(b) A self-identified person in recovery from a substance use or gambling disorder, who meets the abstinence requirements for recovering staff in substance use disorders or gambling treatment and recovery programs; or

(c) A family member of an individual who is a current or former recipient of addictions or mental health services.

(51) "Problem Gambling Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide problem gambling treatment services that include assessment, development of a Service Plan, group and family counseling.

(52) "Program" means a particular type or level of service that is organizationally distinct.

(53) "Program Administrator" or "Program Director" means a person with appropriate professional qualifications and experience, who is designated to manage the operation of a program.

(54) "Program Staff" means an employee or person who, by contract with the program, provides a service and who has the applicable competencies, qualifications or certification, required in this rule to provide the service.

(55) "Provider" means an organizational entity, or qualified person, that is operated by or contractually affiliated with, a community mental health program, or contracted directly with the Division, for the direct delivery of addictions, problem gambling or mental health services and supports.

(56) "Publicly Funded" means financial support, in part or in full, with revenue generated by a local, state or federal government.

(57) "Quality Assessment and Performance Improvement" means the structured, internal monitoring and evaluation of services to improve processes, service delivery and service outcomes.

(58) "Recovery" means a process of healing and transformation for a person to achieve full human potential and personhood in leading a meaningful life in communities of his or her choice.

(59) "Representative" means a person who acts on behalf of an individual, at the individual's request, with respect to a grievance, including, but not limited to a relative, friend, employee of the Division, attorney or legal guardian.

(60) "Resilience" means the universal capacity that a person uses to prevent, minimize, or overcome the effects of adversity. Resilience reflects a person's strengths as protective factors and assets for positive development.

(61) "Residential Substance Use Disorders Treatment Program" means a publicly or privately operated program as defined in ORS 430.010 that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with alcohol and other drug dependence, consistent with Level III of ASAM PCC.

(62) "Residential Problem Gambling Treatment Program" means a publicly or privately operated program that is licensed in accordance with OAR 415-021-0100 through 415-021-0225, that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with gambling related problems.

(63) "Screening" means the process to determine whether the individual needs further assessment to identify circumstances requiring referrals or additional services and supports.

(64) "Service Delivery Rules" means the OAR describing specific regulatory standards for the possible array of services covered by certificates issued under Chapter 309, Division 8 of the OAR.

(65) "Service Plan" means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service.

(67) "Service Note" means the written record of services and supports provided, including documentation of progress toward intended outcomes, consistent with the timelines stated in the Service Plan.

(68) "Service Record" means the documentation, written or electronic, regarding an individual and resulting from entry, assessment, orientation, services and supports planning, services and supports provided, and transfer.

(69) "Services" means those activities and treatments described in the Service Plan that are intended to assist the individual's transition to recovery from a substance use disorder, problem gambling disorder or mental health condition, and to promote resiliency, and rehabilitative and functional individual and family outcomes.

(70) "Signature" means any written or electronic means of entering the name, date of authentication and credentials of the person providing a specific service or the person authorizing services and supports. Signature also means any written or electronic means of entering the name and date of authentication of the individual receiving services, the guardian of the individual receiving services, or any authorized representative of the individual receiving services.

(71) "Skills Training" means providing information and training to individuals and families designed to assist with the development of skills in areas including, but not limited to, anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, symptom management, accessing community services and daily living.

(72) "Substance Abuse Prevention and Treatment Block Grant" or "SAPT Block Grant" means the federal block grants for prevention and treatment of substance abuse under Public Law 102-321 (31 U.S.C. 7301-7305) and the regulations published in Title 45 Part 96 of the Code of Federal Regulations.

(73) "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, and to a toxin exposure. The disorders include substance use disorders such as substance dependence and substance abuse, and substance-induced disorders, including substance intoxication, withdrawal, delirium, and dementia, as well as substance induced psychotic disorder, mood disorder, etc., as defined in DSM criteria.

(74) "Substance Use Disorders Treatment and Recovery Services" means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.

(75) "Substance Use Disorders Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide substance use disorders treatment services that include assessment, development of a Service Plan, and individual, group and family counseling.

(76) "Supports" means activities, referrals and supportive relationships designed to enhance the services delivered to individuals and families for the purpose of facilitating progress toward intended outcomes.

(77) "Transfer" means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.

(78) "Trauma Informed Services" means services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health and addictions services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and are delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services.

(79) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis, that are included in the Service Plan.

(80) "Urinalysis Test" means an initial test and, if positive, a confirmatory test:

(a) An initial test must include, at a minimum, a sensitive, rapid, and inexpensive immunoassay screen to eliminate "true negative" specimens from further consideration.

(b) A confirmatory test is a second analytical procedure used to identify the presence of a specific drug or metabolite in a urine specimen. The confirmatory test must be by a different analytical method from that of the initial test to ensure reliability and accuracy.

(c) All urinalysis tests must be performed by laboratories meeting the requirements of OAR 333-024-0305 to 333-024-0365.

(81) "Urgent" means the onset of symptoms requiring attention within 48 hours to prevent a serious deterioration in an individual's mental or physical health or threat to safety.

(82) "Variance" means an exception from a provision of these rules, granted in writing by the Division, upon written application from the provider. Duration of a variance is determined on a case-by-case basis.

(83) "Volunteer" means an individual who provides a program service or who takes part in a program service and who is not an employee of the program and is not paid for services. The services must be non-clinical unless the individual has the required credentials to provide a clinical service.

(84) "Wellness" means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0107
Certification Required

Entities providing or seeking to provide residential treatment services under these rules must also hold or successfully obtain from the Division a certificate to provide behavioral health treatment services under 309-008-0100 to 309-008-1600 if they intend to provide an outpatient service regulated by HSD's service delivery rules.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0160
Co-Occurring Mental Health and Substance Use Disorders (COD)

Providers approved under OAR 309-008-0100 to 309-008-1600 and designated to provide services and supports for individuals diagnosed with COD must provide concurrent service and support planning and delivery for substance use and mental health diagnosis, including integrated assessment, Service Plan and Service Record.

Stat. Auth.: ORS 430.640 & 443.450
Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0210
Grievances and Appeals

(1) Any individual receiving services, or the parent or guardian of the individual receiving services, may file a grievance with the provider, the individual's managed care plan or the Division.

(2) For individuals whose services are funded by Medicaid, grievance and appeal procedures outlined in OAR 410-141-0260 through 410-141-0266, must be followed.

(3) For individuals whose services are not funded by Medicaid, providers must:

(a) Notify each individual, or guardian, of the grievance procedures by reviewing a written copy of the policy upon entry;

(b) Assist individuals and parents or guardians, as applicable, to understand and complete the grievance process; and notify them of the results and basis for the decision;

(c) Encourage and facilitate resolution of the grievance at the lowest possible level;

(d) Complete an investigation of any grievance within 30 calendar days;

(e) Implement a procedure for accepting, processing and responding to grievances including specific timelines for each;

(f) Designate a program staff person to receive and process the grievance;

(g) Document any action taken on a substantiated grievance within a timely manner; and

(h) Document receipt, investigation and action taken in response to the grievance.

(4) Grievance Process Notice. The provider must have a Grievance Process Notice, which must be posted in a conspicuous place stating the telephone number of:

(a) The Division;

(b) Disability Rights Oregon; and

(c) The applicable managed care organization.

(5) Expedited Grievances: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these rules are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.

(6) Retaliation: A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.

(7) Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

(8) Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:

(a) If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable;

(b) If requested, program staff must be available to assist the individual;

(c) The CMHP Director or Division must provide a written response within ten working days of the receipt of the appeal; and

(d) If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing to the Director, within ten working days of the date of the written response.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-018-0215
Variances

(1) Criteria for a Variance: Variances may be granted to a provider holding a license under this rule:

(a) If there is a lack of resources to implement the standards required in these rules; or

(b) If implementation of the proposed alternative services, methods, concepts or procedures would result in improved outcomes for the individual.

(2) Application for a Variance

(a) Providers may submit their variance request directly to the Division;

(b) Provider requesting a variance must submit a written application to the Division; and

(c) Variance requests must contain the following:

(A) The section of the rule from which the variance is sought;

(B) The reason for the proposed variance;

(C) The alternative practice, service, method, concept or procedure proposed;

(D) A proposal for the duration of the variance; and

(E) A plan and timetable for compliance with the section of the rule for which the variance applies.

(3) Division Review and Notification: The Division must approve or deny the request for a variance and must notify the provider in writing of the decision to approve or deny the requested variance, within 30 days of receipt of the variance. The written notification must include the specific alternative practice, service, method, concept or procedure that is approved and the duration of the approval.

(4) Appeal Application: Appeal of the denial of a variance request must be made in writing to the Chief Officer of the Division, whose decision will be final and must be provided in writing within 30 days of receipt of the appeal.

(5) Written Approval: The LMHA, CMHP or provider may implement a variance only after written approval from the Division.

(6) Duration of Variance: It is the responsibility of the provider to submit a request to extend a variance in writing prior to a variance expiring. Extension must be approved in writing by the Division.

(7) Granting a variance for one request does not set a precedent that must be followed by the Division when evaluating subsequent requests for variance.

Stat. Auth.: ORS 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 10-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 3-2014, f. & cert. ef. 2-3-14; MHS 10-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

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Rule Caption: Temporary amendments to OAR 309-019 titled "Outpatient Addictions and Mental Health Services".
Adm. Order No.: MHS 11-2016(Temp)
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-1-16 thru 12-27-16
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Subject: These rules prescribe minimum standards for services and supports provided by addictions and mental health providers approved by the Health Systems Division of the Oregon Health Authority.
Rules Coordinator: Nola Russell—(503) 945-7652

309-019-0100
Purpose and Scope

(1) Purpose: These rules prescribe minimum service delivery standards for services and supports provided by providers certified by the Health Systems Division of the Oregon Health Authority.

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 943-120-0000 through 943-120-1550, these rules specify standards for behavioral health treatment services and supports provided in:

(a) Outpatient Community Mental Health Services and Supports for Children and Adults;

(b) Outpatient Substance Use Disorders Treatment Services; and

(c) Outpatient Problem Gambling Treatment Services.

Stat. Auth.: ORS 161.390, 413.042 , 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0105
Definitions

(1) "Abuse of an adult" means the circumstances defined in 943-045-0250 through 943-045-0370 for abuse of an adult with mental illness.

(2) "Abuse of a child" means the circumstances defined in ORS 419B.005.

(3) "Addictions and Mental Health Services and Supports" means all services and supports including but not limited to, Outpatient Behavioral Health Services and Supports for Children and Adults, Intensive Treatment Services for Children, Outpatient and Residential Substance Use Disorders Treatment Services and Outpatient and Residential Problem Gambling Treatment Services.

(4) "Adolescent" means an individual from 12 through 17 years of age, or those individuals who are determined to be developmentally appropriate for youth services.

(5) "Adult" means a person 18 years of age or older, or an emancipated minor. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.

(6) "Assessment" means the process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.

(7) "ASAM PPC" means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care, and incorporated by reference in these rules.

(8) "Authority" means the Oregon Health Authority.

(9) "Behavioral Health Treatment": means mental health treatment, substance use disorder treatment, and problem gambling treatment.

(10) "Behavior Support Plan" means the individualized proactive support strategies that are used to support positive behavior.

(11) "Behavior Support Strategies" means proactive supports designed to replace challenging behavior with functional, positive behavior. The strategies address environmental, social, neuro-developmental and physical factors that affect behavior.

(12) "Care Coordination" means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.

(13) "Case Management" means the services provided to assist individuals, who reside in a community setting, or are transitioning to a community setting, in gaining access to needed medical, social, educational, entitlement and other applicable services.

(14) "Certificate" means the document or documents issued by OHA, which identifies and declares certification of a provider pursuant to OAR 309-008-0000. A letter accompanying issuance of the Certificate will detail the scope and approved locations of the Certificate.

(15) "Chief Officer" means the Chief Health Systems Officer of the Division, or his or her designee.

(16) "Child" means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.

(17) "Child and Family Team" means the people who are responsible for creating, implementing, reviewing, and revising the service coordination section of the Service Plan in ICTS programs. At a minimum, the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family.

(18) "Clinical Supervision" means oversight by a qualified Clinical Supervisor of addictions and mental health services and supports provided according to this rule, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(19) "Clinical Supervisor" means a person qualified to oversee and evaluate addictions or mental health services and supports.

(20) "Community-based" means that services and supports must be provided in a participant's home and surrounding community and not solely based in a traditional office-setting.

(a) ACT services may not be provided to individuals residing in an RTF or RTH licensed by HSD, unless:

(A) The individual is not being provided rehabilitative services; or

(B) The individual has been identified for transition to a less intensive level of care. When identified for transition to a less intensive level of care, the individual may receive ACT services for up to six months prior to discharge from the RTH or RTF.

(21) "Competitive Integrated Employment" means full-time or part time work: at minimum wage or higher, at a rate that is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skill; with eligibility for the level of benefits provided to other employees; at a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and as appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

(22)(a) "Comprehensive Assessment" means the organized process of gathering and analyzing current and past information with each individual and the family and/or support system and other significant people to evaluate:

(A) Mental and functional status;

(B) Effectiveness of past treatment;

(C) Current Treatment, rehabilitation and support needs to achieve individual goals and support recovery; and

(D) The range of individual strengths (e.g., knowledge gained from dealing with adversity, personal/professional roles, talents, personal traits) that can act as resources to the individual and his/her recovery planning team in pursuing goals.

(b) The results of the information gathering and analysis are used to:

(A) Establish immediate and longer-term service needs with each individual;

(B) Set goals and develop the first person directed recovery plan with each individual; and,

(C) Optimize benefits that can be derived from existing strengths and resources of the individual and his/her family and/or natural support network in the community.

(23) "Co-Occurring Disorders (COD) Services" include integrated assessment and treatment for individuals who have co-occurring mental health and substance use condition.

(24) "Co-occurring substance use and mental health disorders (COD)" means the existence of a diagnosis of both a substance use disorder and a mental health disorder.

(25) "Coordinated Care Organization (CCO)" means an entity that has been certified by the Authority to provide coordinated and integrated health services.

(26) "Conditional Release" means placement by a court or the Psychiatric Security Review Board (PSRB), of a person who has been found eligible under ORS 161.327(2)(b) or 161.336, for supervision and treatment in a community setting.

(27) "Court" means the last convicting or ruling court unless specifically noted.

(28) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.

(29) "Crisis" means either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care.

(30) "Cultural Competence" means the process by which people and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

(31) "Culturally Specific Program" means a program that is designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture.

(32) "Declaration for Mental Health Treatment" means a written statement of an individual's preferences concerning his or her mental health treatment. The declaration is made when the individual is able to understand and legally make decisions related to such treatment. It is honored, as clinically appropriate, in the event the individual becomes unable to make such decisions.

(33) "Diagnosis" means the principal mental health, substance use or problem gambling diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the assessment and any examinations, tests, or consultations suggested by the assessment, and is the medically appropriate reason for services.

(34) "Division" means the Health Systems Division.

(35) "Division approved reviewer" means the Oregon Center of Excellence for Assertive Community Treatment (OCEACT). OCEACT is the Division's contracted entity that is responsible for conducting ACT fidelity reviews, training, and technical assistance to support new and existing ACT programs statewide.

(36) "DSM" means the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(37) "Driving Under the Influence of Intoxicants (DUII) Substance Use Disorders Rehabilitation Program" means a program of treatment and therapeutically oriented education services for an individual who is either:

(a) A violator of ORS 813.010 Driving Under the Influence of Intoxicants; or

(b) A defendant who is participating in a diversion agreement under ORS 813.200.

(38) "Emergent" means the onset of symptoms requiring attention within 24 hours to prevent serious deterioration in mental or physical health or threat to safety.

(39) "Enhanced Care Services (ECS)" and "Enhanced Care Outreach Services (ECOS)" means intensive behavioral and rehabilitative mental health services to eligible individuals who reside in Aging and People with Disabilities (APD) licensed homes or facilities.

(40) "Entry" means the act or process of acceptance and enrollment into services regulated by this rule.

(41) "Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adoption, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

(42) "Family Support" means the provision of supportive services to persons defined as family to the individual. It includes support to caregivers at community meetings, assistance to families in system navigation and managing multiple appointments, supportive home visits, peer support, parent mentoring and coaching, advocacy, and furthering efforts to develop natural and informal community supports.

(43) "Fixed point of responsibility" means the ACT team itself provides virtually all needed services, rather than sending clients to different providers. If the team cannot provide a service (e.g. dental services) the team ensures that the service is provided.

(44) "Gender Identity" means a person's self-identification of gender, without regard to legal or biological identification, including, but not limited to persons identifying themselves as male, female, transgender and transsexual.

(45) "Gender Presentation" means the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns and social interactions.

(46) "Grievance" means a formal complaint submitted to a provider verbally, or in writing, by an individual, or the individual's chosen representative, pertaining to the denial or delivery of services and supports.

(47) "Guardian" means a person appointed by a court of law to act as guardian of a minor or a legally incapacitated person.

(48) "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

(49) "Hospital discharge planning" for the purposes of the ACT program means a process that begins upon admission to the Oregon State Hospital and that is based on the presumption that with sufficient supports and services, all individuals can live in an integrated community setting. Discharge planning is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on principles of self-determination. Discharge planning teams at OSH include a representative of a community mental health provider from the county where the individual is likely to transition.

(50) "Individual" means any person being considered for or receiving services and supports regulated by these rules.

(51) "Informed Consent for Services" means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the individual and guardian, if applicable, have consented to the services on, or prior to, the first date of service.

(52) "Intensive Outpatient Substance Use Disorders Treatment Services" means structured nonresidential evaluation, treatment, and continued care services for individuals with substance use disorders who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services. Intensive outpatient services may include, but are not limited to, day treatment, correctional day treatment, evening treatment, and partial hospitalization.

(53) "Intensive Community-based Treatment and Support Services (ICTS)" means a specialized set of comprehensive in-home and community-based supports and mental health treatment services, including care coordination as defined in these rules, for children that are developed by the child and family team and delivered in the most integrated setting in the community.

(54) "Interim Referral and Information Services" means services provided by an substance use disorders treatment provider to individuals on a waiting list, and whose services are funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, to reduce the adverse health effects of substance use, promote the health of the individual and reduce the risk of disease transmission.

(55) "Intern" or "Student" means a person who provides a paid or unpaid program service to complete a credentialed or accredited educational program recognized by the state of Oregon.

(56) "Juvenile Psychiatric Security Review Board (JPSRB)" means the entity described in ORS 161.385.

(57) "Level of Care" means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

(58) "Level of Service Intensity Determination." means the Division approved process by which children and young adults in transition are assessed for ITS and ICTS services.

(59) "Licensed Health Care Professional" means a practitioner of the healing arts, acting within the scope of his or her practice under State law, who is licensed by a recognized governing board in Oregon.

(60) "Licensed Medical Practitioner (LMP)" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Physician licensed to practice in the State of Oregon; or

(b) Nurse practitioner licensed to practice in the State of Oregon; or

(c) Physician's Assistant licensed to practice in the State of Oregon; and

(d) Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management.

(e) For ICTS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(61) "Life skills training" means training that help individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

(62) "Local Mental Health Authority (LMHA)" means one of the following entities:

(a) The board of county commissioners of one or more counties that establishes or operates a CMHP;

(b) The tribal council, in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or

(c) A regional local mental health authority comprised of two or more boards of county commissioners.

(63) "Mandatory Reporter" means any public or private official, as defined in ORS 419B.005(3), who comes in contact with or has reasonable cause to believe that an individual has suffered abuse, or that any person with whom the official comes in contact with, has abused the individual. Pursuant to 430.765(2) psychiatrists, psychologists, clergy and attorneys are not mandatory reporters with regard to information received through communications that are privileged under 40.225 to 40.295.

(64) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to eligible persons, under Title XIX of the Social Security Act.

(65) "Medical Director" means a physician licensed to practice medicine in the State of Oregon and who is designated by a substance use disorders treatment program to be responsible for the program's medical services, either as an employee or through a contract.

(66) "Medical Supervision" means an LMP's review and approval, at least annually, of the medical appropriateness of services and supports identified in the Service Plan for each individual receiving mental health services for one or more continuous years.

(67) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis or treatment of a physical or behavioral health condition, 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 and professional standards of care as effective;

(c) Not solely for the convenience of an individual 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 an individual.

(68) "Mental Health Intern" means a person who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work or behavioral science field to meet the educational requirement of QMHP. The person must:

(a) Be currently enrolled in a graduate program for a master's degree in psychology, social work or in a behavioral science field;

(b) Have a collaborative educational agreement with the CMHP, or other provider, and the graduate program;

(c) Work within the scope of his/her practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by provider; and

(d) Receive, at minimum, weekly supervision by a qualified clinical supervisor employed by the provider of services.

(69) "Nursing Services" means services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) within their scope of practice as defined in OAR 851-045-0060.

(70) "Oregon Health Authority" means the Oregon Health Authority of the State of Oregon.

(71) "Outpatient Substance Use Disorders Treatment Program" means a program that provides assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for individuals with alcohol or other drug use disorders and their family members, or significant others.

(72) "Outpatient Community Mental Health Services and Supports" means all outpatient mental health services and supports provided to children, youth and adults.

(73) "Outpatient Problem Gambling Treatment Services" means all outpatient treatment services and supports provided to individuals with gambling related problems and their families.

(74) "Outreach" means the delivery of behavioral health services, referral services and case management services in non-traditional settings, such as, but not limited to, the individual's residence, shelters, streets, jails, transitional housing sites, drop-in centers, single room occupancy hotels, child welfare settings, educational settings or medical settings. It also refers to attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.

(75) "Peer" means any person supporting an individual, or a family member of an individual, who has similar life experience, either as a current or former recipient of addictions or mental health services, or as a family member of an individual who is a current or former recipient of addictions or mental health services.

(76) "Peer Delivered Services" means an array of agency or community-based services and supports provided by peers, and peer support specialists, to individuals or family members with similar lived experience, that are designed to support the needs of individuals and families as applicable.

(77) "Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete a Division approved training program as required by OAR 410-180-0300 to 0380 and be:

(a) A self-identified person currently or formerly receiving mental health services; or

(b) A self-identified person in recovery from a substance use or gambling disorder, who meets the abstinence requirements for recovering staff in substance use disorders or gambling treatment programs; or

(c) A family member of an individual who is a current or former recipient of addictions or mental health services.

(78) "Problem Gambling Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide problem gambling treatment services that include assessment, development of a Service Plan, group and family counseling.

(79) "Program" means a particular type or level of service that is organizationally distinct.

(80) "Program Administrator" or "Program Director" means a person with appropriate professional qualifications and experience, who is designated to manage the operation of a program.

(81) "Program Staff" means an employee or person who, by contract with the program, provides a service and who has the applicable competencies, qualifications or certification, required in this rule to provide the service.

(82) "Provider" means a person, organizational provider, or Community Mental Health Program as designated under ORS 430.637(b) that holds a current Certificate to provide outpatient behavioral health treatment or prevention services pursuant to these and applicable service delivery rules.

(83) "Psychiatric Security Review Board (PSRB)" means the entity described in ORS 161.295 through 161.400.

(84) "Psychiatrist" means a physician licensed pursuant to ORS 677.010 to 677.228 and 677.410 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(85) "Psychiatry services" for the purposes of the ACT program in Oregon means the prescribing and/or administering and reviewing of medications and their side effects, includes both pharmacological management as well as supports and training to the individual. Psychiatry services must be provided by a psychiatrist or a psychiatric nurse practitioner who is licensed by the Oregon Medical Board.

(86) "Psychologist" means a psychologist licensed by the Oregon Board of Psychologist Examiners.

(87) "Publicly Funded" means financial support, in part or in full, with revenue generated by a local, state or federal government.

(88) "Qualified Mental Health Associate (QMHA)" means a person delivering services under the direct supervision of a QMHP who meets the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-019-0125(7).

(89) "Qualified Mental Health Professional (QMHP)" means a LMP or any other person meeting the minimum qualifications as authorized by the LMHA, or designee, and specified in 309-019-0125(8).

(90) "Qualified Person" means a person who is a QMHP, or a QMHA, and is identified by the PSRB and JPSRB in its Conditional Release Order. This person is designated by the provider to deliver or arrange and monitor the provision of the reports and services required by the Conditional Release Order.

(91) "Quality Assessment and Performance Improvement" means the structured, internal monitoring and evaluation of services to improve processes, service delivery and service outcomes.

(92) "Recovery" means a process of healing and transformation for a person to achieve full human potential and personhood in leading a meaningful life in communities of his or her choice.

(93) "Representative" means a person who acts on behalf of an individual, at the individual's request, with respect to a grievance, including, but not limited to a relative, friend, employee of the Division, attorney or legal guardian.

(94) "Resilience" means the universal capacity that a person uses to prevent, minimize, or overcome the effects of adversity. Resilience reflects a person's strengths as protective factors and assets for positive development.

(95) "Respite care" means planned and emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. Respite care can be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the Service Plan.

(96) "Screening" means the process to determine whether the individual needs further assessment to identify circumstances requiring referrals or additional services and supports.

(97) "Screening Specialist" means a person who possesses valid certification issued by the Division to conduct DUII evaluations.

(98) "Service Plan" means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service.

(99) "Service Note" means the written record of services and supports provided, including documentation of progress toward intended outcomes, consistent with the timelines stated in the Service Plan.

(100) "Service Record" means the documentation, written or electronic, regarding an individual and resulting from entry, assessment, orientation, services and supports planning, services and supports provided, and transfer.

(101) "Services" means those activities and treatments described in the Service Plan that are intended to assist the individual's transition to recovery from a substance use disorder, problem gambling disorder or mental health condition, and to promote resiliency, and rehabilitative and functional individual and family outcomes.

(102) "Signature" means any written or electronic means of entering the name, date of authentication and credentials of the person providing a specific service or the person authorizing services and supports. Signature also means any written or electronic means of entering the name and date of authentication of the individual receiving services, the guardian of the individual receiving services, or any authorized representative of the individual receiving services.

(103) "Skills Training" means providing information and training to individuals and families designed to assist with the development of skills in areas including, but not limited to, anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, symptom management, accessing community services and daily living.

(104) "Substance Abuse Prevention and Treatment Block Grant" or "SAPT Block Grant" means the federal block grants for prevention and treatment of substance abuse under Public Law 102-321 (31 U.S.C. 7301-7305) and the regulations published in Title 45 Part 96 of the Code of Federal Regulations.

(105) "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, and to a toxin exposure. The disorders include substance use disorders such as substance dependence and substance abuse, and substance-induced disorders, including substance intoxication, withdrawal, delirium, and dementia, as well as substance induced psychotic disorder, mood disorder, etc., as defined in DSM criteria.

(106) "Substance Use Disorders Treatment and Recovery Services" means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.

(107) "Substance Use Disorders Treatment Staff" means a person certified or licensed by a health or allied provider agency to provide substance use disorders treatment services that include assessment, development of a Service Plan, and individual, group and family counseling.

(108) "Successful DUII Completion" means that the DUII program has documented in its records that for the period of service deemed necessary by the program, the individual has:

(a) Met the completion criteria approved by the Division;

(b) Met the terms of the fee agreement between the provider and the individual; and

(c) Demonstrated 90 days of continuous abstinence prior to completion.

(109) "Supported Employment Services" are individualized services that assist individuals to obtain and maintain integrated, paid, competitive employment. Supported employment services are provided in a manner that seeks to allow individuals to work the maximum number of hours consistent with their preferences, interests and abilities and are individually planned, based on person-centered planning principles and evidence-based practices.

(110) "Supports" means activities, referrals and supportive relationships designed to enhance the services delivered to individuals and families for the purpose of facilitating progress toward intended outcomes.

(111) "Symptom management" means to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment.

(112) "Time-unlimited services" means services are provided not on the basis of predetermined timelines but as long as they are medically appropriate.

(113) "Transfer" means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.

(114) "Trauma Informed Services" means services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health and addictions services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and are delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services.

(115) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis, that are included in the Service Plan.

(116) "Urinalysis Test" means an initial test and, if positive, a confirmatory test:

(a) An initial test must include, at a minimum, a sensitive, rapid, and inexpensive immunoassay screen to eliminate "true negative" specimens from further consideration.

(b) A confirmatory test is a second analytical procedure used to identify the presence of a specific drug or metabolite in a urine specimen. The confirmatory test must be by a different analytical method from that of the initial test to ensure reliability and accuracy.

(c) All urinalysis tests must be performed by laboratories meeting the requirements of OAR 333-024-0305 to 333-024-0365.

(117) "Urgent" means the onset of symptoms requiring attention within 48 hours to prevent a serious deterioration in an individual's mental or physical health or threat to safety.

(118) "Variance" means an exception from a provision of these rules, granted in writing by the Division pursuant to the process regulated by OAR 309-008-1600, upon written application from the provider. Duration of a variance is determined on a case-by-case basis.

(119) "Vocational services" for the purposes of the ACT program in Oregon means employment support services that will lead to competitive integrated employment. The Division encourages the use of fidelity IPS Supported Employment for providing vocational services within the ACT program.

(120) "Volunteer" means an individual who provides a program service or who takes part in a program service and who is not an employee of the program and is not paid for services. The services must be non-clinical unless the individual has the required credentials to provide a clinical service.

(121) "Warm Handoff" means the process of transferring an individual from one provider to another, prior to discharge, which includes face-to-face meeting(s) with an individual, and which coordinates the transfer of responsibility for the individual's ongoing care and continuing treatment and services. A warm handoff shall either:

(a) Include a face-to-face meeting with the community provider and the individual, and if possible, hospital staff; or

(b) Provide a transitional team to support the individual, serve as a bridge between the hospital and the community provider, and ensure that the individual connects with the community provider. For warm handoffs under subparagraph (b), the transitional team shall meet face to face with the individual, and if possible, with hospital staff, prior to discharge. Face-to-face in person meetings are preferable for warm handoffs. However, a face-to-face meeting may be accomplished through technological solutions that provide two-way video-like communication on a secure line ("telehealth"), when either distance is a barrier to an in person meeting or individualized clinical criteria support the use of telehealth.

(122) "Wellness" means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.

(123) "Young Adult in Transition" means an individual who is developmentally transitioning into independence, sometime between the ages of 14 and 25.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0110
Provider Policies

(1) Personnel Policies: All providers must develop and implement written personnel policies and specific procedures, compliant with these rules and other applicable rules or regulatory mandates, including:

(a) Personnel Qualifications and Credentialing;

(b) Mandatory abuse reporting, compliant with ORS 430.735-430.768 and OAR 943-045-0250 through 943-045-0370;

(c) Criminal Records Checks, compliant with ORS 181.533 through 181.575 and 407-007-0000 through 407-007-0370; and

(d) Fraud, waste and abuse in Federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510.

(2) Service Delivery Policies: All providers must develop and implement written service delivery policies and specific procedures, compliant with these rules.

(a) Service delivery policies must be available to individuals and family members upon request; and

(b) Service delivery policies and procedures must include, at a minimum:

(A) Fee agreements;

(B) Confidentiality and compliance with HIPAA, Federal Confidentiality Regulations (42 CFR, Part 2), and State confidentiality regulations as specified in ORS 179.505 and 192.518 through 192.530;

(C) Compliance with Title 2 of the Americans with Disabilities Act of 1990 (ADA);

(D) Grievances and Appeals;

(E) Individual Rights;

(F) Quality Assessment and Performance Improvement;

(G) Trauma Informed Service Delivery, consistent with the AMH Trauma Informed Services Policy;

(H) Provision of culturally and linguistically appropriate services;

(I) Crisis Prevention and Response; and

(J) Incident Reporting.

(3) Behavior Support Policies: Providers of ECS Services must develop policies consistent with 309-019-0155(3) of these rules.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0125

Specific Staff Qualifications and Competencies

(1) Program Administrators or Program Directors must demonstrate competence in leadership, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, use of data, reporting, program evaluation, quality assurance, and developing and coordinating community resources.

(2) Clinical Supervisors in all programs must demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources, group, family and individual therapy or counseling, documentation and rationale for services to promote intended outcomes and implementation of all provider policies.

(3) Clinical supervisors in mental health programs must meet QMHP requirements and have completed two years of post-graduate clinical experience in a mental health treatment setting.

(4) Clinical Supervisors in substance use disorders treatment programs must be certified or licensed by a health or allied provider agency as follows:

(a) For supervisors holding a certification or license in addiction counseling, qualifications for the certificate or license must have included at least:

(A) 4000 hours of supervised experience in substance use counseling;

(B) 300 contact hours of education and training in substance use related subjects; and

(C) Successful completion of a written objective examination or portfolio review by the certifying body.

(b) For supervisors holding a health or allied provider license, the license or registration must have been issued by one of the following state bodies and the supervisor must possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of substance use disorders:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists; or

(E) Board of Nursing.

(c) Additionally, clinical supervisors in substance use disorders programs must have one of the following qualifications:

(A) Five years of paid full-time experience in the field of substance use disorders counseling; or

(B) A Bachelor's degree and four years of paid full-time experience in the social services field, with a minimum of two years of direct substance use disorders counseling experience; or

(C) A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct substance use disorders counseling experience;

(5) Clinical Supervisors in problem gambling treatment programs must meet the requirements for clinical supervisors in either mental health or substance use disorders treatment programs, and have completed 10 hours of gambling specific training within two years of designation as a problem gambling services supervisor.

(6) Substance use disorders treatment staff must:

(a) Demonstrate competence in treatment of substance-use disorders including individual assessment and individual, group, family and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes; and

(b) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide addiction treatment within two years of the first hire date and must make application for certification no later than six months following that date. The two years is not renewable if the person ends employment with a provider and becomes re-employed with another provider.

(c) For treatment staff holding certification in addiction counseling, qualifications for the certificate must have included at least:

(A) 750 hours of supervised experience in substance use counseling;

(B) 150 contact hours of education and training in substance use related subjects; and

(C) Successful completion of a written objective examination or portfolio review by the certifying body.

(d) For treatment staff holding a health or allied provider license, the license or registration must have been issued by one of the following state bodies and the person must possess documentation of at least 60 contact hours of academic or continuing professional education in substance use disorders treatment:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists; or

(E) Board of Nursing.

(7) Problem Gambling treatment staff must:

(a) Demonstrate competence in treatment of problem gambling including individual assessment and individual, group, family and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes.

(b) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide problem gambling treatment within two years of the first hire date and must make application for certification no later than six months following that date. The two years is not renewable if the person ends employment with a provider and becomes re-employed with another provider.

(c) For treatment staff holding certification in problem gambling counseling, qualifications for the certificate must have included at least:

(A) 500 hours of supervised experience in problem gambling counseling;

(B) 60 contact hours of education and training in problem gambling related subjects; and

(C) Successful completion of a written objective examination or portfolio review by the certifying body.

(d) For treatment staff holding a health or allied provider license, the license or registration must have been issued by one of the following state bodies and the person must possess documentation of at least 60 contact hours of academic or continuing professional education in problem gambling treatment:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists; or

(E) Board of Nursing.

(8) QMHAs must demonstrate the ability to communicate effectively, understand mental health assessment, treatment and service terminology and apply each of these concepts, implement skills development strategies, and identify, implement and coordinate the services and supports identified in a Service Plan. In addition, QMHAs must also meet the follow minimum qualifications:

(a) Bachelor's degree in a behavioral science field; or

(b) A combination of at least three years of relevant work, education, training or experience; or

(c) A qualified Mental Health Intern, as defined in 309-019-0105(61).

(9) QMHPs must demonstrate the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting a mental status examination, complete a DSM diagnosis, write and supervise the implementation of a Service Plan and provide individual,

family or group therapy within the scope of their training. In addition, QMHPs must also meet the following minimum qualifications:

(a) Bachelor's degree in nursing and licensed by the State or Oregon;

(b) Bachelor's degree in occupational therapy and licensed by the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in recreational, art, or music therapy;

(f) Graduate degree in a behavioral science field; or

(g) A qualified Mental Health Intern, as defined in 309-019-0105(61).

(10) Peer support specialists must demonstrate knowledge of approaches to support others in recovery and resiliency, and demonstrate efforts at self-directed recovery.

(11) Recovering Staff: Program staff, contractors, volunteers and interns recovering from a substance use disorder, providing treatment services or peer support services in substance use disorders treatment programs, must be able to document continuous abstinence under independent living conditions or recovery housing for the immediate past two years.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.256, 430.640

Stats. Implemented: ORS 109.675, 413.520 - 413.522, 426.380, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 1-2015(Temp), f. & cert. ef. 3-25-15 thru 9-20-15; MHS 3-2015, f. & cert. ef. 5-28-15; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0130

Personnel Documentation, Training and Supervision

(1) Providers must maintain personnel records for each program staff which contains all of the following documentation:

(a) Where required, verification of a criminal record check consistent with OAR 407-007-0000 through 407-007-0370;

(b) A current job description that includes applicable competencies;

(c) Copies of relevant licensure or certification, diploma, or certified transcripts from an accredited college, indicating that the program staff meets applicable qualifications;

(d) Periodic performance appraisals;

(e) Staff orientation documentation; and

(f) Disciplinary documentation;

(g) Documentation of trainings required by this or other applicable rules; and

(h) Documentation of clinical and non-clinical supervision.

(2) Providers utilizing contractors, interns or volunteers must maintain the following documentation, as applicable:

(a) A contract or written agreement;

(b) A signed confidentiality agreement;

(c) Orientation documentation; and

(d) For subject individuals, verification of a criminal records check consistent with OAR 407-007-0000 through 407-007-0370.

(3) Training: Providers must ensure that program staff receives training applicable to the specific population for whom services are planned, delivered, or supervised as follows:

(a) Orientation training: The program must document appropriate orientation training for each program staff, or person providing services, within 30 days of the hire date. At minimum, orientation training for all program staff must include, but not be limited to,

(A) A review of crisis prevention and response procedures;

(B) A review of emergency evacuation procedures;

(C) A review of program policies and procedures;

(D) A review of rights for individuals receiving services and supports;

(E) Mandatory abuse reporting procedures;

(F) HIPAA, and Fraud, Waste and Abuse;

(G) Planning and implementing a warm handoff; and

(H) For Enhanced Care Services, positive behavior support training.

(4) Clinical Supervision: Persons providing direct services must receive supervision by a qualified Clinical Supervisor, as defined in these rules, related to the development, implementation and outcome of services.

(a) Clinical supervision must be provided to assist program staff and volunteers to increase their skills, improve quality of services to individuals, and supervise program staff and volunteers' compliance with program policies and procedures, including:

(b) Documentation of two hours per month of supervision for each person supervised. The two hours must include one hour of individual face-to-face contact for each person supervised, or a proportional level of supervision for part-time program staff. Individual face-to-face contact may include real time, two-way audio visual conferencing;

(c) Documentation of two hours of quarterly supervision for program staff holding a health or allied provider license, including at least one hour of individual face-to-face contact for each person supervised; or

(d) Documentation of weekly supervision for program staff meeting the definition of Mental Health Intern.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.256, 430.640

Stats. Implemented: ORS 109.675, 413.520 - 413.522, 426.380, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0140

Service Plan and Service Notes

(1) The Service Plan must be a written, individualized plan to improve the individual's condition to the point where the individual's continued participation in the program is no longer necessary. The Service Plan is included in the individual's service record and must:

(a) Be completed prior to the start of services;

(b) Reflect the assessment and the level of care to be provided;

(c) Include the participation of the individual and family members, as applicable;

(d) Include a description of all warm handoff planning and implementation; and

(d) Be completed by qualified program staff as follows:

(A) A QMHP in mental health programs;

(B) Supervisory or treatment staff in substance use disorders treatment programs, and

(C) Supervisory or treatment staff in problem gambling treatment programs.

(e) For mental health services, a QMHP, who is also a licensed health care professional, must recommend the services and supports by signing the Service plan within ten (10) business days of the start of services; and

(f) A LMP must approve the Service Plan at least annually for each individual receiving mental health services for one or more continuous years. The LMP may designate annual clinical oversight by documenting the designation to a specific licensed health care professional.

(2) At minimum, each Service Plan must include:

(a) Individualized treatment objectives;

(b) The specific services and supports that will be used to meet the treatment objectives;

(c) A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter;

(d) The type of personnel that will be furnishing the services; and

(e) A projected schedule for re-evaluating the Service Plan.

(3) Service Notes:

(a) Providers must document each service and support. A Service Note, at minimum, must include:

(A) The specific services rendered;

(B) The date, time of service, and the actual amount of time the services were rendered;

(C) Who rendered the services;

(D) The setting in which the services were rendered;

(E) The relationship of the services to the treatment regimen described in the Service Plan; and

(F) Periodic Updates describing the individual's progress.

(4) Decisions to transfer individuals must be documented, including the reason for the transfer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640

Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0145

Co-Occurring Mental Health and Substance Use Disorders (COD)

Providers approved under OAR 309-008-0000 and designated to provide services and supports for individuals diagnosed with COD must provide concurrent service and support planning and delivery for substance use, gambling disorder, and mental health diagnosis, including integrated assessment, Service Plan and Service Record.

Stat. Auth.: ORS 430.640

Stats. Implemented: ORS 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955

Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0195
DUII Rehabilitation Programs

(1) In addition to the general standards for substance use disorders treatment programs, those programs approved to provide DUII rehabilitation services must meet the following standards:

(a) DUII rehabilitation programs must assess individuals referred for treatment by the screening specialist. Placement, continued stay and transfer of individuals must be based on the criteria described in the ASAM PPC, subject to the following additional terms and conditions:

(A) Abstinence: Individuals must demonstrate continuous abstinence for a minimum of 90 days prior to completion as documented by urinalysis tests and other evidence;

(B) Treatment Completion: Only DUII rehabilitation programs may certify treatment completion;

(C) Residential Treatment: Using the criteria from the ASAM PPC, the DUII program's assessment may indicate that the individual requires treatment in a residential program. When the individual is in residential treatment, it is the responsibility of the DUII program to:

(i) Monitor the case carefully while the individual is in residential treatment;

(ii) Provide or monitor outpatient and follow-up services when the individual is transferred from the residential program; and

(iii) Verify completion of residential treatment and follow-up outpatient treatment.

(2) Urinalysis Testing: A minimum of one urinalysis sample per month must be collected during the period of service, the total number deemed necessary to be determined by an individual's DUII rehabilitation program:

(a) Using the process defined in these rules, the samples must be tested for at least five controlled drugs, including alcohol;

(b) At least one of the samples is to be collected and tested in the first two weeks of the program and at least one is to be collected and tested in the last two weeks of the program;

(c) If the first sample is positive, two or more samples must be collected and tested, including one sample within the last two weeks before completion; and

(d) Programs may use methods of testing for the presence of alcohol and other drugs in the individual's body other than urinalysis tests if they have obtained the prior review and approval of such methods by the Division.

(3) Reporting: The program must report:

(a) To the Division on forms prescribed by the Division;

(b) To the screening specialist within 30 days from the date of the referral by the screening specialist. Subsequent reports must be provided within 30 days of completion or within 10 days of the time that the individual enters noncompliant status; and

(c) To the appropriate screening specialist, case manager, court, or other agency as required when requested concerning individual cooperation, attendance, treatment progress, utilized modalities, and fee payment.

(4) Certifying Completion: The program must send a numbered Certificate of Completion to the Department of Motor Vehicles to verify the completion of convicted individuals. Payment for treatment may be considered in determining completion. A certificate of completion must not be issued until the individual has:

(a) Met the completion criteria approved by the Division;

(b) Met the terms of the fee agreement between the provider and the individual; and

(c) Demonstrated 90 days of continuous abstinence prior to completion.

(5) Records: The DUII rehabilitation program must maintain in the permanent Service Record, urinalysis results and all information necessary to determine whether the program is being, or has been, successfully completed.

(6) Separation of Screening and Rehabilitation Functions: Without the approval of the Chief Officer, no agency or person may provide DUII rehabilitation to an individual who has also been referred by a Judge to the same agency or person for a DUII screening. Failure to comply with this rule will be considered a violation of ORS chapter 813. If the Chief Officer finds such a violation, the Chief Officer may deny, suspend, revoke, or refuse to renew a letter of approval.

Stat. Auth.: ORS 161.390, 413.042, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 161.390 - 161.400, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0215
Grievances and Appeals

(1) Any individual receiving services, or the parent or guardian of the individual receiving services, may file a grievance with the provider, the individual's managed care plan or the Division.

(2) For individuals whose services are funded by Medicaid, grievance and appeal procedures outlined in OAR 410-141-0260 through 410-141-0266, must be followed.

(3) For individuals whose services are not funded by Medicaid, providers must:

(a) Notify each individual, or guardian, of the grievance procedures by reviewing a written copy of the policy upon entry;

(b) Assist individuals and parents or guardians, as applicable, to understand and complete the grievance process; and notify them of the results and basis for the decision;

(c) Encourage and facilitate resolution of the grievance at the lowest possible level;

(d) Complete an investigation of any grievance within 30 calendar days;

(e) Implement a procedure for accepting, processing and responding to grievances including specific timelines for each;

(f) Designate a program staff person to receive and process the grievance;

(g) Document any action taken on a substantiated grievance within a timely manner; and

(h) Document receipt, investigation and action taken in response to the grievance.

(4) Grievance Process Notice. The provider must have a Grievance Process Notice, which must be posted in a conspicuous place stating the telephone number of:

(a) The Division;

(b) Disability Rights Oregon; and

(c) The applicable managed care organization.

(5) Expedited Grievances: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these rules are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.

(6) Retaliation: A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.

(7) Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

(8) Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:

(a) If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the Division as applicable;

(b) If requested, program staff must be available to assist the individual;

(c) The Division, must provide a written response within ten working days of the receipt of the appeal; and

(d) If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the Chief Officer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0220
Variances

(1) Requirements and standards for requesting and granting variances or exceptions are found in OAR 309-008-1600.

(2) Division Review and Notification: The Chief Officer of the Division must approve or deny the request for a variance to these rules within the scope and authority The Division must be made in writing using the Division approved variance request form and following the variance

request procedure compliant with OAR 309-008-1600. (3) Granting a variance for one request does not set a precedent that must be followed by the Division when evaluating subsequent requests for variance.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 6-2013(Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0225
ACT Overview

(1) The Substance Abuse and Mental Health Services Administration (SAMHSA) characterizes ACT as an evidence-based practice for individuals with a serious and persistent mental illness. ACT is characterized by:

(a) A team approach;

(b) Community based;

(c) A small client to staff caseload, typically 10:1, to consistently provide necessary staffing diversity and coverage;

(d) Time-unlimited services;

(e) Flexible service delivery;

(f) A fixed point of responsibility; and

(g) 24/7 crisis availability.

(2) ACT services include, but are not limited to:

(a) Hospital discharge planning;

(b) Case management;

(c) Symptom management;

(d) Psychiatry services;

(e) Nursing services;

(f) Co-occurring substance use and mental health disorders treatment services;

(g) Vocational services;

(h) Life skills training; and

(i) Peer support services.

(2) SAMHSA characterizes a high fidelity ACT Program as one that includes the following staff members:

(a) Psychiatrist or Psychiatric Nurse Practitioner;

(b) Psychiatric Nurse(s);

(c) Qualified Mental Health Professional (QMHP) ACT Team Supervisor;

(d) Qualified Mental Health Professional(s) (QMHP) Mental Health Clinician;

(e) Substance Abuse Treatment Specialist;

(f) Employment Specialist;

(g) Housing Specialist;

(h) Mental Health Case Manager; and

(i) Certified Peer Support Specialist.

(3) SAMHSA characterizes a high fidelity ACT Program as one that adheres to the following protocols:

(a) Explicit admission criteria that has an identified mission to serve a particular population and uses measurable and operationally defined criteria;

(b) Intake rate: ACT eligible individuals are admitted to the program at a low rate to maintain a stable service environment;

(c) Full responsibility for treatment services which includes, at a minimum, case management, psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services;

(d) Twenty four-hour responsibility for covering psychiatric crises;

(e) Involvement in psychiatric hospital admissions;

(f) Involvement in planning for hospital discharges; and

(g) Time-unlimited services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0230
ACT Provider Qualifications

(1) In order to be eligible for Medicaid or State General Fund reimbursement, ACT services shall be provided only by those providers meeting the following minimum qualifications:

(a) The provider must hold and maintain a current certificate under OAR 309-008, issued by the Division, for the purpose of providing behavioral health treatment services; and

(b) The provider must hold and maintain a current certificate, issued by the Division, under OAR 309-019-0210 through 309-019-0245, for the purpose of providing Assertive Community Treatment; and

(c) A provider certified to provide ACT services under this rule must be reviewed annually for fidelity adherence by the Division approved reviewer and achieve a minimum score of 114 on the fidelity scale. Providers shall not bill Medicaid or use General Funds unless they are subject to an annual fidelity review by the Division approved reviewer.

(A) The Division approved reviewer shall forward a copy of the annual fidelity review report to the Division approved reviewer and provide a copy of the review to the provider.

(B) The provider shall forward a copy of the annual fidelity review report to the appropriate CCO.

(2) A Provider already holding a certificate of approval under OAR 309-008 may request the addition of ACT services be added to their certificate of approval via the procedure outlined in OAR 309-008-0400 and 309-008-1000(1). In addition to application materials required in OAR 309-008 and this rule, the provider must also submit to the Division a letter of support which indicates receipt of technical assistance and training from the Division approved ACT reviewer.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0235
Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0230, in order to maintain a ACT provider designation on the Division issued certificate, a provider must submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 114.

(2) Providers certified to provide ACT services under this rule that achieve a fidelity score of 128 or better when reviewed by the Division Approved ACT Reviewer are eligible to extend their fidelity review period to every 18 months.

(a) Extension of Fidelity reviews has no bearing on the frequency of re-certification reviews required under OAR 309-008.

(3) Fidelity reviews will be conducted utilizing the Substance Abuse and Mental Health Services ACT Toolkit Fidelity Scale, which will be made available to providers electronically

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0240
Failure to Meet Fidelity Standards

(1) In addition to any plan of correction requirements issued by the Division under 309-008-0800(4)(c); If a Provider certified under these rules to provide ACT services does not receive a minimum score of 114 on a fidelity review, the following shall occur:

(a) Technical assistance shall be made available by the Division approved reviewer for a period of 90 days to address problem areas identified in the fidelity review;

(b) At the end of the 90 day period, a follow-up review will be conducted by the Division approved reviewer; and

(c) The provider shall forward a copy of the amended fidelity review report to the provider's appropriate CCO.

(d) The Division approved reviewer shall forward a copy of the fidelity review report to the Division.

(2) In addition to the standards set for suspension and revocation of a certificate in OAR 309-008-1100(1) and (2) a provider of ACT services may also have their certificate of approval suspended or revoked if the 90 day re-review results in a fidelity score of less than 114.

(3) A provider issued a notice of intent to apply a condition, revoke, suspend, or refusal to renew its certificate under these rules shall be entitled to request a hearing in accordance with ORS Chapter 183 and OAR 309-008-1300.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0245
Admission Criteria

(1) Participants must meet the Medically Appropriate standard as designated in OAR 309-019-0105. Participants who are Medically Appropriate must have the following characteristics:

(a) Participants diagnosed with severe and persistent mental illness as listed in the Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability.

(b) Participants with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder or intellectual disabilities are not the intended client group.)

(c) Participants with significant functional impairments as demonstrated by at least one of the following conditions:

(A) Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.

(B) Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).

(C) Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

(d) Participants with one or more of the following problems, which are indicators of continuous high service needs (i.e., greater than eight hours per month):

(A) High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.

(B) Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).

(C) Coexisting substance abuse disorder of significant duration (e.g., greater than 6 months).

(D) High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).

(E) Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.

(F) Residing in an inpatient or supervised community residence in the community where ACT services are available, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.

(G) Difficulty effectively utilizing traditional office-based outpatient services.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0248
Admission Process

(1) A comprehensive assessment as described in OAR 309-019-0105(6) that demonstrates medical appropriateness must be completed prior to the provision of this service. If a substantially equivalent assessment is available, that reflects current level of functioning, and contains standards consistent with OAR 309-019-0135, to include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services, the equivalent assessment may be used to determine admission eligibility for the program.

(2) Admission to ACT is managed through a referral process that is coordinated by a designated single point of contact (SPOC) that represents the Coordinated Care Organization's (CCO) and/or Community Mental Health Program's (CMHP) geographical service area.

(a) The designated single point of contact shall accept referrals and verify the required documentation supports the referral for services.

(b) OHA will work with the CCOs and the CMHPs to identify regional SPOCs.

(c) OHA will work with the CCOs and the CMHPs to identify a process where referrals can be received and tracked.

(3) An admission decision by the designated SPOC must be completed and reported to the Division within seven (7) business days of receiving the referral. To accomplish this, the SPOC must be fully informed as to the current capacity of ACT programs within the SPOC's geographic service area at all times.

(4) All referrals for ACT services must be submitted through the designated regional SPOC, regardless of the origin of the referral. The designated regional SPOC shall accept and evaluate referrals from mental health outpatient programs, residential treatment facilities or homes, families and/or individuals, and other referring sources.

(5) Given the severity of mental illness and functional impairment of individuals who qualify for ACT-level services, the final decision to admit a referral rests with the provider. Any referral to a provider should therefore present a full picture of the individual by means of the supporting medical documentation attached to the OHA Universal ACT Referral and Tracking Form. An admission decision by the ACT services provider must be completed within five (5) business days of receiving the referral.

(a) The individual's decision not to take psychiatric medication is not a sufficient reason for denying admission to an ACT program.

(b) ACT capacity in a geographic regional service area is not a sufficient reason for not providing ACT services to an ACT eligible individual. If an individual who is ACT eligible cannot be served due to capacity, the SPOC must provide individual with the option of being added to a waiting list until such time the ACT eligible individual can be admitted to a qualified ACT program.

(6) Upon the decision to admit an individual to the ACT program, the OHA Universal ACT Referral and Tracking Form shall be updated, to include:

(a) An admission is indicated.

(b) When an admission is not indicated, notation shall be made of the following:

(A) The reason(s) for not admitting;

(B) The disposition of the case; and

(C) Any referrals or recommendations made to the referring agency, as appropriate.

(7) Individuals who meet admission criteria and are not admitted to an ACT program due to program capacity, may elect to be placed on a waiting list. The waiting list will be maintained by the appropriate regional SPOC. OHA will monitor each regional waiting list until sufficient ACT program capacity is developed to meet the needs of the ACT eligible population.

(8) In addition if an individual is denied ACT services and has met the admission criteria set forth in OAR 309-019-045, the individual who is denied services or their guardian may appeal the decision by filing a grievance in the manner set forth in OAR 309-008-1500.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0250
Transition to Less Intensive Services

(1) Transition to less intensive services shall occur when the individual no longer requires ACT level of care and is no longer medically appropriate for ACT services. This shall occur when individuals receiving ACT:

(a) Have successfully reached individually established goals for transition.

(b) Have successfully demonstrated an ability to function in all major role areas (i.e. work, social, self-care) without ongoing assistance from the ACT provider;

(c) When the individual requests discharge, declines, or refuses services; and

(d) When the individual moves outside of the geographic area of the ACT program's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT provider or another provider wherever the individual is moving. The ACT team shall maintain contact with the individual until this service is implemented.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

309-019-0255
Reporting Requirements

Providers certified by the Division to provide ACT shall submit quarterly outcomes reports, using forms and procedures prescribed by the Division, within 45 days following the end of each subject quarter to the Division or the Division approved reviewer. Each quarterly report shall provide the following information:

(1) Individuals served;

(a) Individuals who are homeless at any point during a quarter;

(b) Individuals with safe stable housing for 6 months;

(c) Individuals using emergency departments during each quarter for a mental health reason;

(d) Individuals hospitalized in OSH or in an acute psychiatric facility during each quarter;

(e) Individuals hospitalized in an acute care psychiatric facility during each quarter;

(f) Individuals in jail at any point during each quarter;

(g) Individuals receiving Supported Employment Services during each quarter;

(h) Individuals who are employed in competitive integrated employment, as defined above.

(2) Individuals receiving ACT services that are not enrolled in Medicaid

(3) Referrals and Outcomes

(a) Number of referrals received during each quarter;

(b) Number of individuals accepted during each quarter;

(c) Number of individuals admitted during each quarter; and

(d) Number of individuals denied during each quarter and the reason for each denial.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 413.520 - 413.522, 430.010, 430.205-430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 11-2016(Temp), f. 6-29-16, cert. ef. 7-1-16 thru 12-27-16

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Oregon Health Authority, Public Employees' Benefit Board
Chapter 101

Rule Caption: In the matter of PEBB permanently amending rules to comply with Senate Bill 204.
Adm. Order No.: PEBB 1-2016
Filed with Sec. of State: 7-12-2016
Certified to be Effective: 7-12-16
Notice Publication Date: 6-1-2016
Rules Amended: 101-020-0060, 101-020-0065, 101-030-0015
Rules Repealed: 101-030-0020
Subject: In the matter of PEBB permanently amending rules to comply with Senate Bill 204.
Rules Coordinator: Cherie Taylor—(503) 378-6296

101-020-0060
Dependent Care Flexible Spending Account

(1) Employees can use a Dependent Care Flexible Spending account (Dependent Care FSA) to be reimbursed for employment-related dependent care expenses that allow the employee and his or her spouse to be "gainfully employed." The plan is subject to federal Revenue Code requirements and Internal Revenue Service regulations.

(2) Employees enrolled in a Dependent Care FSA contribute a pre-tax amount from each month's salary during the plan year. Employees receive reimbursement from the account during the plan year for incurred qualified Dependent Care expenses by submitting a claim.

(3) FSA plans are annual plans, employees must enroll for each plan year to participate. The enrollment does not roll over from one plan year to the next. All plan year FSA enrollments terminate December 31. The period of coverage is the 12 months during the plan year.

(4) An employee's pretax contribution under a Dependent Care FSA in a calendar year is (not exhaustive list):

(a) $5,000 if the employee is married and filing a joint return or if the employee is single parent.

(b) $2,500 if the employee is married but files separately.

(c) When a spouse's employer also has a dependent care FSA plan, the $5000 limit applies to the total amount of pre-tax dependent care assistance that the employee and his or her spouse, as a couple, can receive in any tax year from all employer-sponsored plans.

(d) The limit is not affected by the number of qualified persons an employee has.

(5) To qualify as employment-related dependent care expenses, the expenses must be incurred in order to enable the employee (and the employee's spouse) to be gainfully employed. The dependent care must have been for qualifying individuals. In general (not exhaustive) a qualifying individual is a tax dependent who is:

(a) A dependent of the taxpayer (i.e., a qualifying child) who has not attained age 13; or

(b) A dependent of the taxpayer (i.e., a qualifying child or a qualifying relative) who is physically or mentally incapable of caring for himself or herself; and has the same principal place of residence as the taxpayer for more than half of the year; or

(c) The spouse of the taxpayer if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of residence as the taxpayer for more than half the year.

(6) The annual contribution to the account cannot exceed the allowable federal annual maximum.

(a) The employee's monthly contribution is the annual contribution election amount pro-rated per each month of the plan year.

(b) PEBB requires a minimum monthly contribution amount.

(c) An employee may make only one FSA contribution each month of the plan year.

(d) An employee may not change their contribution unless they experience a qualified mid-year plan change event that allows the change.

(e) Some higher education agency employees may have fewer months (9 or 10) of contribution during the plan year.

(7) Claims are reimbursed for qualified expenses incurred while the dependent care FSA coverage was actively in force. Active participation ends the last day of the month that a contribution is received for that month.

(a) The amount of reimbursement available to a participant at any time during the period of coverage is restricted to the amount previously contributed by the participant, less any amounts reimbursed.

(b) A reimbursement exception is made for eligible expenses incurred in the month following the employee's end of participation or loss of plan eligibility, if the month is in the current plan year (not during the grace period) and the employee submits a claim within 90 days after the plan participation end date.

(8) A qualified claim and reimbursement grace period extends through March 15 of each new plan year. During the grace period, FSA participants may incur claims against any remaining previous plan year FSA funds up to March 15 in the new plan year. The qualified claim submission deadline for previous plan year account fund reimbursements is March 31 of the new plan year.

(9) FSAs are "use it or lose it" accounts. Any previous plan year funds remaining in the account beyond March 31 of the new plan year forfeit to PEBB plan administration.

(10) The Dependent Care FSA contributions can continue during a protected leave such as FMLA/OFLA, CBIW, or Active Military Duty; however, in general, most claims incurred during the leave will not be eligible for reimbursement.

(a) Employees may revoke the FSA account enrollment during the approved protected leave.

(b) Employees taking a LWOP and not in a protected leave will have their Dependent Care FSA revoked during the leave.

(c) Employees canceling the Dependent Care FSA when going on a leave can reenroll in the plan when they return to work.

(11) Final contribution at termination of employment or leave.

(a) An OSPS employee will not have a contribution taken from their final paycheck.

Example: Ann's last day of work is September 16. Her final check will not have a contribution taken. Ann's participation ends September 30 and her period of coverage could be through October 31.

(b) An OUS employee who meets the 80-hour work rule will have a contribution taken from their final paycheck, in accordance with OAR 101-020-0002.

Example 1: Ann's last day of work is June 6. She has less than 80 hours of work for the month. Ann's final check will not have a contribution taken. Ann's participation ends May 31 and her period of coverage could be through June 30.

Example 2: Ann's last day of work is June 20. She has more than 80 hours of work for the month. Ann's final check will have a contribution taken. Ann's participation ends June 30, and her period of coverage could be through July 31.

(12) An eligible employee who separates from the employer and returns to work in a benefit eligible position within 12 months is not reinstated in the Dependent Care FSA. They may enroll within 30 days of their new benefit eligible date.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302

Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; Renumbered from 101-040-0050, PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07; PEBB 3-2009, f. 9-29-09 cert. ef. 10-1-09; PEBB 1-2016, f. & cert. ef. 7-12-16

101-020-0065
Health Flexible Spending Arrangement

(1) An eligible employee may enroll in a pretax Health Flexible Spending Arrangement (Health FSA). A Health Care Flexible Spending Arrangement (Health Care FSA) is regulated by various federal government regulations. Health Care FSAs can be defined in part by the following categories.

(a) It is a self-insured medical reimbursement plan subject to certain Internal Revenue Code requirements.

(b) It is a flexible spending account subject to additional requirements in the IRS regulations.

(c) It is a group health plan subject to CORBA, HIPAA, health care reform and other federal mandates that affect group health plans.

(2) Employees enrolled in a health care FSA contribute a pre-tax amount from each month's salary during the plan year. Employees receive reimbursement from the account for qualified incurred health expenses during the plan year by submitting claims.

(3) Eligible employees must enroll for each plan year in order to participate. FSA plan enrollments do not roll over from one plan year to the next. All plan year FSA enrollments terminate December 31.The period of coverage is the 12 months during PEBB's plan year.

(4) The annual employee contribution to the FSA account cannot exceed the allowable federal annual maximum.

(a) The employee's monthly contribution is the employee's elected annual contribution amount pro-rated per each month of the plan year.

(b) PEBB requires a minimum monthly contribution amount.

(c) An employee may make only one FSA contribution each month of the plan year.

(d) An employee may not change their monthly contribution unless they experience a qualified mid-year plan change event that allows the change.

(e) Some higher education agency employees may have fewer months (9 or 10) of contribution during the plan year.

(5) FSA accounts have uniform coverage. Uniform coverage means that an employee's maximum contribution amount for the plan year is available at all times while the account is active. The amount available is reduced for prior reimbursements made in the current plan year. Uniform coverage is provided throughout the period of coverage.

(6) Expenses must be incurred by the employee, spouse, the employee's children who have not attained age 27 as of the end of the employee's taxable year, or who are the employee's tax dependents for health coverage purposes.

(7) A grace period for qualified claim and reimbursement extends through March 15 of each new plan year. During the grace period, FSA participants may incur claims against any remaining previous plan year FSA funds up to March 15 in the new plan year. The qualified claim submission deadline for previous plan year account fund reimbursements is March 31 of the new plan year.

(8) FSAs are "use it or lose it" accounts. Any previous plan year funds remaining in the account beyond March 31 of the new plan year forfeit to PEBB plan administration.

(9) Employees taking an approved protected leave, for example FMLA/OFLA, CBIW, or Active Military Duty Leave are entitled to continuation of the their health FSA while on the leave.

(a) If the leave is a substituted paid leave, then the employee's contribution for continuation must be paid by payroll deduction.

(b) An agency may offer one or more of the following options to an employee who continues the FSA account coverage while on a protected unpaid leave. Before commencing the leave, or shortly thereafter, the employee and the agency must agree to one of the following options for employee contribution.

(A) Prepay. The employee is given the opportunity to prepay their premium share due during the leave period before the leave begins. The prepay option cannot be the sole option offered to employees on approved protected leave.

(B) Pay as you go. The employee pays the cost of coverage in installments during the leave. Contributions are paid with after-tax dollars or with pre-tax dollars to the extent that the employee receives compensation (e.g., unused sick or vacation days) during the leave.

(C) Catch-up options. The employer and employee agree in advance that the employer will advance payment of the employee's share of the contribution during the leave and that the employee will repay the advanced amounts when the employee returns to work.

(D) Revoke Coverage. Employees may revoke the FSA account enrollment during the leave.

(10) An employer is not required to continue the benefits of an employee who fails to make required payments while on a protected leave provided notice procedures are followed. Refer to OAR 1010-20-0002(7)(d) for employee non-payment notices and benefit termination. If the employer chooses to continue the health coverage of an employee who fails to pay his or her share of the premium or contribution payments, the employer is permitted to recoup the employee's premium.

(11) Employees who terminate FSA participation during the plan year can receive reimbursement for qualified claim expenses incurred while the health FSA coverage was actively in force. No reimbursement is allowed for expenses incurred after the account terminates. Active participation ends the last day of the month that a contribution is received for that month.

(12) OUS and some academic OSPS employees that enroll based on their 9- or 10-month pay contributions are considered actively participating during the months of no contribution. For example, during months of June and July when they are not actively at work.

(13) Final contribution at termination of employment or a leave without pay terminating the FSA:

(a) OSPS, the employee will not have a contribution taken from their final paycheck.

Example: Ann's last day of work is September 16. Her final check will not have a contribution taken. Ann's participation ends September 30 and her period of coverage is through September 30.

(b) An OUS employee who meets the 80-hour work rule will have a contribution taken from their final paycheck, in accordance with OAR 101-020-0002.

Example 1: Ann's last day of work is June 6. She has less than 80 hours of work for the month. Ann's final check will not have a contribution taken. Ann's participation ends May 31 and her period of coverage is through May 31.

Example 2: Ann's last day of work is June 20. She has more than 80 hours of work for the month. Ann's final check will have a contribution taken. Ann's participation ends June 30, and her period of coverage is through June 30.

(14) An eligible employee terminating employment or going on an approved unprotected leave of absence, may continue to participate in the Health FSA up to the end of the current plan year through COBRA. There must be a positive FSA account balance and all contributions are paid post tax to the COBRA administrator.

(15) When called to active duty for a period of at least 180 days or for an indefinite period, and employee can request a qualified reservist distribution from a Health FSA. The eligible employee must be a member of the Army National Guard of the United States, the Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard of the United States, Air Force Reserve, Coast Guard Reserve, or Reserve Corps of the Public Health Service.

(a) The following conditions must be met by the eligible employee in order to elect the qualified reservist distribution:

(A) Contributions to the Health FSA account for the plan year as of the date of the request for a distribution exceed the reimbursements received from the Health FSA Account for the plan year as of that date.

(B) The agency receives a copy of the order or call to active duty along with the distribution request form. An order or call to active duty of less than 180 days duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.

(C) During the period beginning with the date of the order or call to active duty and ending on the last eligible day of the plan year during which the order or call occurred, the employee submits a qualified reservist distribution election form to the agency.

Example: An eligible employee is called to active duty on September 13, of the current plan year and wants a Health FSA qualified reservist distribution. The employee must request the qualified reservist distribution between September 13, and March of the following plan year.

(b) The distribution amount paid to the eligible employee is equal to the contributions to the Health FSA Account for the plan year as of the date of the distribution request, minus any reimbursements received by the employee for the plan year as of that date. A qualified reservist distribution is included in an eligible employee's gross income and reported as wages for the year it is paid.

Example: An eligible employee elects Health FSA benefits of $1,000 for the current plan year, and during the first six months of the plan year, makes Health FSA contributions of $500 and receives Health FSA reimbursements of $200 for qualified medical care expenses. The employee is called to active duty for an indefinite period and on June 30 requests a reservist distribution from the agency. The employee will receive a distribution of $300, and the agency must add that amount to the employees' taxable wages for the current tax year.

(c) The Health FSA Account is closed as of the date of the request for a reservist distribution. An employee forfeits the right to receive reim-

bursements for medical care expenses incurred during the period that begins on the date of the distribution request and ending on the last day of the Plan Year.

(16) An employee who separates from the employer and returns to work in a benefit eligible position within 12 months is not reinstated in the Health Care FSA. They may enroll within 30 days of their new benefit eligible date.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061 - 243.302
Hist.: PEBB 2-2004(Temp), f. 7-13-04, cert. ef. 8-31-04 thru 2-27-05; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; Renumbered from 101-040-0055, PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07; PEBB 3-2009, f. 9-29-09 cert. ef. 10-1-09; PEBB 1-2016, f. & cert. ef. 7-12-16

101-030-0015
Continuation of Core Benefit Coverage for Employees Covered under the Federal Family Medical Leave Act (FMLA) and the Oregon Family Leave Act (OFLA)

(1) Employees taking approved FMLA or OFLA leave are entitled to the continuation of employer provided health coverage. The agency is obligated to maintain the employee's health coverage under the same conditions that would have applied had the employee not been in leave.

(a) If the FMLA or OFLA leave is substituted paid leave, then the employee's share of premiums for continuation must be paid by payroll deduction.

(b) An agency may offer one or more of the following options, to an employee who continues core benefit coverage while on an unpaid FMLA or OFLA leave. Before commencing the leave, or shortly thereafter, the employee and the agency must agree to one of the following options for employee premium share.

(A) Prepay. The employee is given the opportunity to prepay their premium share due during the leave period before the leave begins. The prepay option cannot be the sole option offered to employees on FMLA or OFLA leave.

(B) Pay as you go. The employee pays the cost of coverage in installments during the leave. Contributions are paid with after-tax dollars or with pre-tax dollars to the extent that the employee receives compensation (e.g. unused sick or vacation days) during the leave.

(C) Catch-up options. The employer and employee agree in advance that the employer will advance payment of the employee's share of the cost of coverage during the leave and that the employee will repay the advanced amounts when the employee returns to work.

(D) Revoke Coverage. Employees may revoke the employer offered core health coverages during the leave. In this event the agency sends a COBRA notice of availability.

(2) Employees enrolled as Opt Out, receiving cash in lieu of medical benefits, do not receive the monthly payment when in leave without pay status, regardless of approved FMLA or OFLA leave.

(3) An employer is not required to continue the benefits of an employee who fails to make required payments while on FMLA or OFLA leave provided notice procedures are followed. Refer to OAR 1010-20-0002(7)(d) for employee non-payment notices and benefit termination. If the employer chooses to continue the health coverage of an employee who fails to pay his or her share of the premium payments the employer is permitted to recoup the employee's premium.

(4) A Health Care FSA is a group health plan under FMLA or OFLA. Refer to OAR 101-020-0065(9) regarding required payment options during a FMLA or OFLA leave. Prepayment cannot be the only method offered for FSA continuation during FMLA or OFLA leaves.

(5) An eligible employee may continue the following optional plans during the approved FMLA leave by self-paying premiums or contributions to the agency:

(a) All Optional Life Insurances:

(b) Short Term and Long Term Disability,

(c) Accidental Death and Dismemberment Insurance:

(d) Long Term Care

(6) An agency must provide a benefit eligible employee who is in FMLA or OFLA leave during the annual open enrollment period the opportunity to select benefits for the coming plan year.

(7) An employee returning to paid regular status the first day following the end of an approved FMLA or OFLA leave or as scheduled, or an employee in a current benefit eligible stability period is not required to work at least half-time in the month of return to be eligible for benefits the following month. Core benefits and optional coverages are reinstated if available retroactive to the first day of the month that the employee returns to work.

(a) The employee must self-pay premiums for optional insurance plan reinstatements for the month in which they return.

(b) An employee returning to work will not be reinstated in Long Term Care.

(c) An employee's FSA enrollment status, active or terminated, will depend on the employee's FSA continuation status during the leave. If the employee's FSA enrollment terminated during the leave the employee may enroll.

(8) An employee that waives all coverages for the leave period and returns to paid regular status beyond 30 days of loss of coverage but within 12 months from the loss of coverage, is reinstated to coverage and can make midyear plan changes within 30 days of the date they return to work. This includes enrollment for a FSA account or long term care.

(9) An employee who does not return to paid regular status the first work day immediately following the end of approved FMLA or OFLA leave as scheduled, and is not in a current benefit eligible stability period is considered the same as if returning from an unprotected leave without pay. The employee is required to work at least half time 80 hours in the month of return to receive reinstated benefits the following month. See OAR 101-020-0045(2)(a).

(10) A COBRA qualifying event occurs when (i) the employee does not return to work as scheduled the first day after the qualified leave ends and is not in a current stability status, or (ii) the employee terminates employment.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061–302, 659.A150-186
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07; PEBB 2-2008, f. & cert. ef. 8-1-08; PEBB 7-2010, f. 12-10-10, cert. ef. 1-1-11; PEBB 3-2014(Temp), f. & cert. ef. 11-12-14 thru 5-10-15; PEBB 1-2015, f. & cert. ef. 5-12-15; PEBB 1-2016, f. & cert. ef. 7-12-16

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Oregon Health Authority, Public Health Division
Chapter 333

Rule Caption: Standards for Reducing the Sale of Tobacco and Inhalant Delivery Systems to Minors
Adm. Order No.: PH 19-2016
Filed with Sec. of State: 6-24-2016
Certified to be Effective: 6-24-16
Notice Publication Date: 4-1-2016
Rules Amended: 333-015-0200, 333-015-0205, 333-015-0210, 333-015-0215, 333-015-0220
Rules Repealed: 333-015-0200(T), 333-015-0205(T), 333-015-0210(T), 333-015-0215(T), 333-015-0220(T)
Subject: The Oregon Health Authority (Authority), Public Health Division is permanently ammending administrative rules in chapter 333, division 15 pertaining to standards for reducing the sale of tobacco and inhalant delivery systems to minors. This permanent rulemaking will make temporary rules effective January 1, 2016 through June 28, 2016 permanent.

The permanent rules:

1. Create definitions in rules to reflect the purpose of the statute, and add clarity to the rules.

2. Require tobacco and inhalant delivery system retailers to post a notice substantially similar to the content of notice as defined in rules.

3. Adds inhalant delivery systems to requirements specifying the location tobacco products within a retail store.

4. Add inhalant delivery systems to the Authority's enforcement activities for implementing sales to minors regulations.

Rules Coordinator: Tracy Candela—(971) 673-0561

333-015-0200
Definitions

(1) "Authority" means the Oregon Health Authority.

(2) "Block grant" means the Substance Abuse Prevention and Treatment Block Grant pursuant to 42 USC 300x21e et seq.

(3)(a) "Inhalant delivery system" means:

(A) A device that can be used to deliver nicotine or cannabinoids in the form of a vapor or aerosol to a person inhaling from the device; or

(B) A component of a device described in this subsection or a substance in any form sold for the purpose of being vaporized or aerosolized

by a device described in this subsection, whether the component or substance is sold separately or is not sold separately.

(b) Inhalant delivery system does not include:

(A) Any product that has been approved by the United States Food and Drug Administration for sale as a tobacco cessation product or for any other therapeutic purpose, if the product is marketed and sold solely for the approved purpose; and

(B) Tobacco products.

(4) "Minor" means an individual under 18 years of age.

(5) "Outlet" means any location which sells at retail or otherwise distributes tobacco products or inhalant delivery systems to consumers including, but not limited to, locations that sell such products over the counter or through vending machines.

(6) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(7) "Smoking instrument" means any cigar, cigarette, pipe or other instrument used to smoke tobacco, marijuana, cocaine or other inhalant as defined in ORS 433.835 and ORS 163.575.

(8) "Tobacco product" means bidis, cigars, cheroots, stogies, periques, granulated, plug cut, crimp cut, ready rubbed and other smoking tobacco, snuff, snuff flour, cavendish, shisha, hookah tobacco, plug and twist tobacco, fine-cut and other chewing tobaccos, shorts, refuse scraps, clippings, cutting and sweepings of tobacco prepared in such a manner as to be suitable for chewing or smoking in a pipe or otherwise, or both for chewing and smoking, and cigarettes as defined in ORS 431A.175.

(9) "Vending machine" means a mechanical, electronic or similar device that, upon the insertion of tokens, money or another form of payment, dispense tobacco products or inhalant delivery systems as defined in ORS 167.402.

Stat. Auth.: ORS 431.853
Stats. Implemented: ORS 431.853
Hist.: PH 32-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; PH 19-2016, f. & cert. ef. 6-24-16

333-015-0205
Notice Posting Requirement

(1) An outlet must post a notice substantially similar to the notice described in section (2) of this rule in a location that is clearly visible to the seller and the purchaser.

(2) Content of the Notice: NOTICE: The sale of tobacco products, smoking instruments and inhalant delivery systems to persons under 18 years of age is prohibited by law. Any person who sells, or allows to be sold, a tobacco product, smoking instrument or inhalant delivery system to a person under 18 years of age is in violation of Oregon law.

(3) The Authority may impose a civil penalty for each violation of this rule that is not less than $250 or more than $1,000.

Stat. Auth.: ORS 431.840, 431.845
Stats. Implemented: 431.840, 431.845
Hist.: PH 32-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; PH 19-2016, f. & cert. ef. 6-24-16

333-015-0210
Location of Tobacco Products Within a Retail Store

(1) A person having authority over the location of tobacco products or inhalant delivery systems in a retail store may not locate the tobacco products or inhalant delivery systems in a location where the tobacco products or inhalant delivery systems are accessible by store customers without assistance by a store employee.

(2) This rule does not apply to a person if the location at which the tobacco products or inhalant delivery systems are sold is a store or other establishment at which persons under 18 years of age are prohibited.

Stat. Auth.: ORS 163.575, 167.400, 167.402, 167.407, 431.840, 431.853
Stats. Implemented: ORS 431.853
Hist.: PH 32-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; PH 19-2016, f. & cert. ef. 6-24-16

333-015-0215
Enforcement

(1) The Authority shall coordinate with law enforcement agencies to conduct random, unannounced inspections of wholesalers and retailers of tobacco products, smoking instruments or inhalant delivery systems to ensure compliance with, and to enforce, the laws of this state designed to discourage the sale of tobacco products, smoking instruments and inhalant delivery systems to minors. Nothing in these rules shall preempt local jurisdictions from passing ordinances to conduct unannounced inspections.

(2) Random Sample Procedures: Random, unannounced inspections will be based on the following methodological procedures

(a) Cover a range of outlets, not to be preselected on the basis of prior violations, to measure overall levels of compliance as well as to identify violations;

(b) Be conducted in such a way as to provide a probability sample of outlets in order to estimate the success of enforcement actions being taken throughout the state;

(c) Use reliable methodological design and adequate sample design to reflect:

(A) Distribution of the population of those under 18 throughout the state; and

(B) Distribution of outlets throughout the state that are accessible to minors; and

(d) Be conducted at times when minors are likely to purchase tobacco products, smoking instruments or inhalant delivery systems.

(3) Targeted Inspections: The Authority may conduct targeted inspections of outlets where a compliance problem exists or is suspected. Information gained in targeted inspection will not be included in data used to determine rate of offense in random inspections.

(4) Conducting Inspections: Inspections may take place:

(a) Only in areas open to the public;

(b) Only during the hours that tobacco products, smoking instruments or inhalant delivery systems are sold; and

(c) No more frequently than once a month in any single outlet unless a compliance problem exists or is suspected. For purposes of this rule, a "single outlet" refers to a specific address location of an outlet, regardless of ownership.

(5) The Authority may use minors to complete inspections to determine compliance with these rules.

Stat. Auth.: ORS 431.853
Stats. Implemented: ORS 431.853
Hist.: PH 32-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; PH 19-2016, f. & cert. ef. 6-24-16

333-015-0220
Annual Report

(1) Contents of Report: The Authority shall annually submit a report to the Oregon Legislature and to the Secretary, along with the state's application for block grant funding. The report shall include:

(a) A description of the state's activities to enforce the laws described in OAR 333-015-0200 through OAR 333-015-0215 during the fiscal year preceding the fiscal year for which the state is seeking the grant;

(b) A description outlining the overall success the state has achieved during the previous fiscal year in reducing the availability of tobacco products, smoking instruments and inhalant delivery systems to individuals under the age of 18, showing:

(A) Results of the random and targeted unannounced inspections;

(B) Results of over-the-counter and vending machine outlet inspections reported separately;

(c) A description of how the unannounced inspections were conducted and the methods used to identify outlets; and

(d) Strategies to be utilized by the state for enforcing such laws during the fiscal year for which the grant is sought.

(2) Public Comment Required: The annual report shall be made public and public comment shall be obtained and considered before submitting the report to the Secretary.

Stat. Auth.: ORS 431.853
Stats. Implemented: ORS 431.853
Hist.: PH 32-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-28-16; PH 19-2016, f. & cert. ef. 6-24-16

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Rule Caption: Packaging and Labeling Requirements for Inhalant Delivery Systems
Adm. Order No.: PH 20-2016
Filed with Sec. of State: 6-24-2016
Certified to be Effective: 6-24-16
Notice Publication Date: 4-1-2016
Rules Adopted: 333-015-0300, 333-015-0305, 333-015-0310, 333-015-0320, 333-015-0325, 333-015-0340, 333-015-0345, 333-015-0350, 333-015-0355, 333-015-0360, 333-015-0365, 333-015-0370, 333-015-0375
Subject: The Oregon Health Authority, Public Health Division permanently adopting administrative rules in chapter 333, division 15

regarding packaging and labeling requirements for inhalant delivery systems.

1. Creates definitions in rules to reflect the purpose of the statute, and add clarity to the rules.

2. Requires that inhalant delivery systems are not "Packaged in a manner attractive to minors," as defined in rules.

3. Requires that inhalant delivery systems display labels that conform to the labeling standards set forth in 16 CFR 1700.20 and 21 CFR Parts 1100, 1140 & 1143.

4. Establishes civil penalty amounts and enforcement schedule for violations of the rules.

Rules Coordinator: Tracy Candela—(971) 673-0561

333-015-0300
Purpose, Scope and Effective Date

(1) The purpose of OAR 333-015-0305 to 333-015-0375 is to set the minimum standards for the labeling and packaging of inhalant delivery systems that are sold to a consumer.

(2) These minimum standards are applicable on and after July 1, 2016.

(3) These rules do not apply to an inhalant delivery system or prefilled inhalant delivery system that contains cannabinoids if that inhalant delivery system or prefilled inhalant delivery system complies with the packaging requirements in OAR 845-025-7000 to 845-025-7060 and the labeling requirements in OAR 333-007-0010 to 333-007-0100.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0305
Definitions

For the purposes of OAR 333-015-0300 to 333-015-0375:

(1) "Authority" means the Oregon Health Authority.

(2) "Cannabinoid" means any of the chemical compounds that are the active constituents of marijuana.

(3) "Cartoon" means any drawing or other depiction of an object, person, animal or creature or any similar caricature that satisfies any of the following criteria:

(a) The use of exaggerated features;

(b) The attribution of human characteristics to animals, plants or other objects, or the similar use of anthropomorphic technique; or

(c) The attribution of unnatural or extra-human abilities, such as imperviousness to pain or injury, X-ray vision, tunneling at very high speeds or transformation.

(4) "Child-resistant" means packaging that is:

(a) Intended to protect children from nicotine exposure in the household environment or other environment where the product is used;

(b) Designed or constructed to be significantly difficult for children under five years of age to open and not difficult for adults to use properly, as defined by 16 CFR 1700.20 (1995); and

(c) Re-sealable for any product intended for more than a single use, such as a fillable inhalant delivery system.

(5) "Consumer product" means any article, or component part thereof, produced or distributed for sale to a consumer for use in or around a permanent or temporary household or residence, a school, in recreation, or otherwise, or for the personal use, consumption or enjoyment of a consumer in or around a permanent or temporary household or residence, a school, in recreation, or otherwise.

(6) "Distributor" means a person or company that supplies stores or businesses with goods.

(7) "Fillable inhalant delivery system" means a product that is sold without nicotine or non-nicotine inhalants, not permanently sealed and can be opened and filled with any inhalant.

(8) "Inhalant" means nicotine, or any other substance that:

(a) Is in a form that allows the nicotine, cannabinoid or substance to be delivered into a person's respiratory system;

(b) Is inhaled for the purpose of delivering the nicotine, cannabinoid or other substance into a person's respiratory system; and

(c)(A) Is not approved by, or emitted by a device approved by, the United States Food and Drug Administration (FDA) for a therapeutic purpose; or

(B) If approved by, or emitted by a device approved by, the United States Food and Drug Administration for a therapeutic purpose, is not marketed and sold solely for that purpose.

(9)(a) "Inhalant delivery system" means:

(A) A device that can be used to deliver nicotine or cannabinoids in the form of a vapor or aerosol to a person inhaling from the device; or

(B) A component of a device described in this section or a substance in any form sold for the purpose of being vaporized or aerosolized by a device described in this section, whether the component or substance is sold separately or is not sold separately.

(b)(A) Inhalant delivery system does not include any product that has been approved by the United States Food and Drug Administration for sale as a tobacco cessation product or for any other therapeutic purpose, if the product is marketed and sold solely for the approved purpose; and

(B) Tobacco products.

(10) "Inner package" means the package that must be opened by a consumer in order to have access to the product and that may also be but is not required to be the outer package.

(11) "Liquid nicotine container" means a consumer product that consists of a container that:

(a) Has an opening from which nicotine in a solution or other form is accessible and can flow freely through normal and foreseeable use by a consumer; and

(b) Is used to hold soluble nicotine in any concentration.

(12) "Manufacturer or distributor contact information" means the name, city, state and country of the manufacturer who made the inhalant delivery system.

(13) "Minor" means an individual under 18 years of age.

(14) "Nicotine" means any form of the chemical nicotine, including any salt or complex, regardless of whether the chemical is naturally or synthetically derived.

(15) "Non-nicotine liquid container" means a container that:

(a) Has an opening from which liquid non-nicotine or liquid non-cannabinoid substances can flow freely through normal and foreseeable use by a consumer; and

(b) Is not used to hold liquid nicotine or cannabinoids.

(16) "Outer package" means the external package visible to a consumer in the retail setting such as, but not limited to, a box or container.

(17) "Outlet" means any location in Oregon which sells at retail or otherwise distributes tobacco products or inhalant delivery systems to consumers including, but not limited to, locations that sell such products over the counter or through vending machines.

(18) "Packaged in a manner attractive to minors" means an inhalant delivery system product where any package, including the outer package or label on the outer package, or the inner package or label on the inner package:

(a) Depicts cartoons;

(b) Depicts celebrities or fictitious characters played by people;

(c) Depicts people using the product;

(d) Depicts food or beverage;

(e) Resembles any product of the type that is typically marketed to minors; or

(f) Resembles the shape of any animal, commercially recognizable toy or candy.

(19) "Prefilled inhalant delivery system" means an inhalant delivery system that is permanently sealed, prefilled, disposable and not intended to be disassembled by the consumer.

(20) "Retail setting" means a place of business in which merchandise is primarily sold directly to an ultimate consumer.

(21) "These rules" means OAR 333-015-0300 to 333-015-0375.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0310
Labeling Requirements for Liquid Nicotine Containers

A label on a liquid nicotine container must conform to the labeling standards set forth in 21 CFR Parts 1100, 1140 and 1143.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0320
Labeling Requirements for Prefilled Inhalant Delivery Systems

A label on a prefilled inhalant delivery system must conform to the labeling standards set forth in 21 CFR Parts 1100, 1140 and 1143.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0325
Labeling Requirements for Fillable Inhalant Delivery Systems

A label on a fillable inhalant delivery system must conform to the labeling standards set forth in 21 CFR Parts 1100, 1140 and 1143.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0340
Packaging Requirements for Liquid Nicotine Containers

A liquid nicotine container for sale to a consumer:

(1) Must be:

(a) In child-resistant safety packaging; and

(b) Labeled in accordance with these rules.

(2) May not be placed in an inner or outer package that is attractive to minors.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0345
Packaging Requirements for Non-nicotine Liquid Containers

A non-nicotine liquid container for sale to a consumer:

(1) Must be:

(a) In child-resistant safety packaging; and

(2) May not be placed in an inner or outer package that is attractive to minors.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0350
Packaging Requirements for Prefilled Inhalant Delivery Systems

A prefilled inhalant delivery system for sale to a consumer:

(1) Must be labeled in accordance with these rules.

(2) May not be placed in an inner or outer package that is attractive to minors.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0355
Packaging Requirements for Fillable Inhalant Delivery Systems

(1) A fillable inhalant delivery system that is not packaged with a liquid nicotine container for sale to a consumer:

(a) Must be labeled in accordance with these rules.

(b) May not be packaged in any packaging, including an inner or outer package, that is attractive to minors.

(2) A fillable inhalant delivery system that is packaged with a liquid nicotine container for sale to a consumer must comply with OAR 333-015-0340.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0360
Verification of Child-Resistant Packaging

Oregon-based outlets must provide verification of a manufacturer's written laboratory testing report describing child-resistant packaging results based on using the protocol set forth in 16 CFR 1700.20 (1995) to the Authority upon the Authority's request.

Stat. Auth.: ORS 431A.175
Stats. Implemented: ORS 431A.175
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0365
Inspections

The Authority shall coordinate random, unannounced inspections of Oregon-based outlets of inhalant delivery systems to ensure compliance with these rules.

Stat. Auth.: ORS 431A.183
Stats. Implemented: ORS 431A.183
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0370
Violations

It is a violation for a manufacturer, retailer or distributor to:

(1) Distribute, sell or allow to be sold an inhalant delivery device that does not comply with a labeling requirement in OAR 333-015-0310 to 333-015-0030.

(2) Distribute, sell or allow to be sold an inhalant delivery device that does not comply with a packaging requirement in OAR 333-015-0340 to 333-015-0360.

Stat. Auth.: ORS 431A.175, 431A.178
Stats. Implemented: ORS 431A.175, 431A.178
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

333-015-0375
Civil Penalties

(1) The Authority may impose a civil penalty for each violation of 333-015-0340 to 333-015-0360 against a manufacturer, retailer or distributor according to the following schedule:

(a) $0 together with the issuance of a warning letter to the retailer for the first violation

(b) Minimum of $500 for the second violation within a 24-month period of the first violation.

(c) Minimum of $800 for the third violation within a 24-month period of the second violation.

(d) Minimum of $2000 for the fourth violation within a 24-month period of the third violation.

(e) Minimum of $8000 for the fifth violation within a 36-month period of the fourth violation.

(f) Minimum of $15,000 for the sixth or subsequent violation within a 48-month period of the fifth violation.

(2) A civil penalty may not to exceed $15,000 for each violation or $1,050,000 for all violations found in a single inspection.

(3) Each product that does not comply with these rules or that is distributed, sold, or allowed to be sold in violation of these rules is a separate violation. For example, if 10 liquid nicotine containers are distributed, sold, or allowed to be sold without child-resistant packaging the civil penalty could be $5000 (10 x $500).

Stat. Auth.: ORS 431A.178
Stats. Implemented: ORS 431A.178
Hist.: PH 20-2016, f. & cert. ef. 6-24-16

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Rule Caption: Marijuana Labeling, Concentration Limits and Testing. Medical Marijuana Growers, Processors, Dispensaries and Patients
Adm. Order No.: PH 21-2016
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Rules Repealed: 333-008-1073, 333-008-1640, 333-007-0010(T), 333-007-0020(T), 333-007-0030(T), 333-007-0040(T), 333-007-0050(T), 333-007-0060(T), 333-007-0070(T), 333-007-0080(T), 333-007-0083(T), 333-007-0085(T), 333-007-0090(T), 333-007-0100(T), 333-007-0200(T), 333-007-0210(T), 333-007-0220(T), 333-008-1225(T), 333-008-0300(T), 333-008-0310(T), 333-007-0315(T), 333-007-0320(T), 333-007-0330(T), 333-007-0340(T), 333-007-0350(T), 333-007-0360(T), 333-007-0370(T), 333-007-

0380(T), 333-007-0390(T), 333-007-0400(T), 333-007-0410(T), 333-007-0420(T), 333-007-0430(T), 333-007-0440(T), 333-007-0450(T), 333-007-0460, 333-007-0470(T), 333-007-0480(T), 333-007-0490(T), 333-064-0100(T), 333-064-0110(T)

Subject: The Oregon Health Authority (OHA), Public Health Division is permanently adopting amending and repealing rules in chapter 333, division 7, 8 and 64 related to marijuana product serving size and concentration limits, marijuana labeling and marijuana laboratory sampling and testing; and pertaining to medical marijuana growers, processors, dispensaries and patient cards.

House Bill 3400 (Oregon Laws 2015, chapter 614) made many changes to the Oregon Medical Marijuana Act, including directing the Oregon Health Authority, in consultation with the Oregon Liquor Control Commission (OLCC) and the Oregon Department of Agriculture (ODA), to protect public safety by establishing rules on marijuana laboratory sampling and testing, marijuana labeling, marijuana product serving size and concentration limits.

In order to protect public health and safety, these rules establish standards for the sampling and testing of marijuana items, including, but not limited to, tests for pesticides, solvents, microbiological contaminants, and tetrahydrocannabinol and cannabidiol concentration. In addition, the rules on testing establish sampling procedures for marijuana items and the reporting of test results. The rules establish labeling standards of marijuana items ensuring that labels include, among other things, health and safety warnings, product content, activation time, THC concentration levels and laboratory testing information. The rules also establish the maximum concentration of THC that is permitted in a marijuana item or single serving of a marijuana item, and the number of servings permitted in a marijuana item.

On and after October 1, 2016, all marijuana items sold in a medical marijuana dispensary or in a retail establishment licensed by the OLCC will be required to meet these labeling, concentration limit and serving size standards established by the Authority.

OLCC licenses will be required to comply with the sampling and testing requirements at all times.

Changes to chapter 333, division 8 of the Oregon Administrative Rules are necessary to implement SB 1511, (Oregon Laws 2016, chapter 83), SB 1598 (Oregon Laws 2016, chapter 23) and HB 4014 (Oregon Laws 2016, chapter 24). In addition, certain housekeeping measures are necessary for rules governing processors and dispensaries to more adequately reflect the intent of the rules that were filed on March 1, 2016. Revisions to these rules include, but are not limited to, the following areas:

-Fees for patient applicants who have served in the armed forces;

-The residency requirements for persons responsible for marijuana grow sites (PRMG), persons responsible for a dispensary, and persons responsible for a marijuana processing site;

-The issuance of a receipt to a patient applicant;

-Requirements for Grandfathered grow sites;

-Grow site plant limits;

-Delegation of reporting and documentation requirements by a PRMG;

-Land use compatibility statements from local governments;

-Dispensary premises restrictions and requirements;

-Transfers of marijuana by a patient or designated primary caregiver to a registered processing site and transfers from a registered processing site to a patient or designated primary caregiver;

-Required reporting by registered processing sites to the Authority; and

-Security, camera and video requirements.

Rules Coordinator: Tracy Candela—(971) 673-0561

333-007-0010
Purpose, Scope and Effective Date

(1) The purpose of OAR 333-007-0010 through 333-007-0100 is to set the minimum standards for the labeling of marijuana items that are sold to a consumer, patient or designated primary caregiver. These minimum standards are applicable to:

(a) A Commission licensee as that is defined in OAR 845-025-1015; and

(b) A person registered with the Authority under ORS 475B.400 to 475B.525 who is not exempt from the labeling requirements as described in section (2) of this rule.

(2) The labeling requirements in these rules do not apply to:

(a) A grower if the grower is transferring usable marijuana or an immature marijuana plant to:

(A) A patient who designated the grower to grow marijuana for the patient; or

(B) A designated primary caregiver of the patient who designated the grower to grow marijuana for the patient.

(b) A designated primary caregiver of a patient if the caregiver is transferring a marijuana item to a patient of the designated primary caregiver.

(3) Nothing in these rules prohibits the Commission or the Authority from:

(a) Imposing additional labeling requirements in their respective rules governing licensees and registrants as long as those additional labeling requirements are not inconsistent with these rules; or

(b) Requiring licensees or registrants to provide informational material to a consumer, patient or designated primary caregiver at the point of sale.

(4) A person licensed by the Commission must comply with these rules at all times.

(5) On and after October 1, 2016:

(a) A marijuana item received or transferred by a dispensary must meet the labeling requirements in these rules; and

(b) A dispensary may not transfer a marijuana item that does not meet the labeling requirements in these rules.

(6) By October 1, 2016, a dispensary must:

(a) Transfer marijuana items that do not meet the labeling requirements in these rules to a patient or caregiver;

(b) Return any marijuana item that does not meet labeling requirements in these rules to the individual who transferred the item to the dispensary, and document who the item was returned to, what was returned and the date of the return; or

(c) Dispose of any marijuana item that does not meet labeling requirements and that cannot be returned in accordance with subsection (b) of this section, in a manner specified by the Authority.

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 4-2016(Temp), f. & cert. ef. 2-8-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0020
Definitions

For the purposes of OAR 333-007-0100 through 333-007-0100, unless otherwise specified:

(1) "Activation time" means the amount of time it is likely to take for an individual to begin to feel the effects of ingesting or inhaling a marijuana item.

(2) "Authority" means the Oregon Health Authority.

(3) "Cannabinoid concentrate or extract" means a substance obtained by separating cannabinoids from marijuana by a mechanical, chemical or other process.

(4)(a) "Cannabinoid edible" means:

(A) Food or potable liquid into which a cannabinoid concentrate or extract or the dried leaves or flowers of marijuana have been incorporated; or

(B) For purposes of labeling, includes any cannabinoid concentrate, extract or cannabinoid product that is intended for human consumption or marketed in a manner that implies the item is for human consumption.

(b) For purposes of labeling "cannabinoid edible" does not include a cannabinoid tincture.

(5)(a) "Cannabinoid product" means a cannabinoid edible or any other product intended for human consumption or use, including a product intended to be applied to a person's skin or hair, that contains cannabinoids or the dried leaves or flowers of marijuana.

(b) "Cannabinoid product" does not include:

(A) Usable marijuana by itself;

(B) A cannabinoid concentrate or extract by itself; or

(C) Industrial hemp, as defined in ORS 571.300.

(6) "Cannabinoid tincture" means a solution of alcohol, cannabinoid concentrate or extract, and perhaps other ingredients intended for human

consumption or ingestion, and that is exempt from the Liquor Control Act under ORS 471.035.

(7) "Cannabinoid topical" means a cannabinoid product intended to be applied to skin or hair.

(8) "CBD" means cannabidiol.

(9) "Commission" means the Oregon Liquor Control Commission.

(10) "Consumer" has the meaning given that term in ORS 475B.015 and does not include a patient or designated primary caregiver.

(11) "Container"

(a) Means a sealed, hard or soft-bodied receptacle in which a marijuana item is placed.

(b) Does not mean inner wrapping or packaging that is not intended to display the marijuana item for sale to a consumer.

(12) "Date of harvest" means the date the mature marijuana plants in a harvest lot were removed from the soil or other growing media. If the harvest occurred on more than one day, the "date of harvest" is the day the last mature marijuana plant in the harvest lot was removed from the soil or other growing media.

(13) "Delta-9 THC" is the principal psychoactive constituent (the principal cannabinoid) of cannabis.

(14)(a) "Designated primary caregiver" means an individual:

(A) Who is 18 years of age or older;

(B) Who has significant responsibility for managing the well-being of a person who has been diagnosed with a debilitating medical condition; and

(C) Who is designated as the person responsible for managing the well-being of a person who has been diagnosed with a debilitating medical condition on that person's application for a registry identification card or in other written notification submitted to the Authority.

(b) "Designated primary caregiver" does not include a person's attending physician.

(15) "Food" means a raw, cooked, or processed edible substance, or ingredient used or intended for use or for sale in whole or in part for human consumption, or chewing gum.

(16) "Grower" has the same meaning as "person responsible for a marijuana grow site."

(17) "Harvest lot" means marijuana that is uniform in strain, cultivated utilizing the same growing practices and harvested at the same time.

(18) "Human consumption" means to ingest, generally through the mouth, food, drink or other substances such that the substance enters the human body but does not include inhalation.

(19) "Licensee" has the meaning given that term in ORS 475B.015.

(20) "Major food allergen" means an ingredient that is one of the five foods listed in subsections (a) to (e) of this section, or from one of the three food groups listed in subsections (f) to (h) of this section, or is an ingredient that contains protein derived from one of the following:

(a) Milk;

(b) Egg;

(c) Fish;

(d) Crustacean shellfish;

(e) Tree nuts;

(f) Wheat;

(g) Peanuts; and

(h) Soybeans.

(21)(a) "Marijuana" means the plant Cannabis family Cannabaceae, any part of the plant Cannabis family Cannabaceae and the seeds of the plant Cannabis family Cannabaceae.

(b) "Marijuana" does not include industrial hemp, as defined in ORS 571.300.

(22) "Marijuana item" means marijuana, usable marijuana, a cannabinoid product, or a cannabinoid concentrate or extract.

(23) "Medical grade cannabinoid product, cannabinoid concentrate or cannabinoid extract" means a cannabinoid product, cannabinoid concentrate or cannabinoid extract that has a concentration of THC that is permitted under ORS 475B.625 in a single serving of the cannabinoid product, cannabinoid concentrate or cannabinoid extract for a patient.

(24) "Medical grade symbol" means the image established by the Authority and made available to licensees indicating the cannabinoid product, concentrate or extract may only be sold or transferred to a designated primary caregiver or patient, for use only by a patient.

(25) "Medical marijuana dispensary" means a facility registered under ORS 475B.450.

(26) "Net weight" means the gross weight minus the tare weight of the packaging.

(27) "Package unique identification number" mean the unique identification number that was generated by the Commission's seed to sale tracking system at the time the marijuana item was packaged and labeled for sale to the consumer, patient, or designated primary caregiver.

(28) "Patient" has the same meaning as "registry identification cardholder."

(29) "Person responsible for a marijuana grow site" means a person who has been selected by a patient to produce medical marijuana for the patient, and who has been registered by the Authority for this purpose and has the same meaning as "grower."

(30) "Place of address" means the name, mailing address, city, state and zip code of the processor who made the cannabinoid edible.

(31) "Principal display panel" means the part of a label on a package or container that is most likely to be displayed, presented, shown or seen under customary conditions of display for sale or transfer.

(32) "Processor" means a person:

(a) Licensed by the Commission to process marijuana under ORS 475B.090; or

(b) Registered with the Authority under ORS 475B.435 as a processing site and who is not exempt from labeling requirements under ORS 475B.605

(33) "Process lot" means:

(a) Any amount of cannabinoid concentrate or extract of the same type and processed at the same time using the same extraction methods, standard operating procedures and batches from the same or different harvest lots; or

(b) Any amount of cannabinoid products of the same type and processed at the same time using the same ingredients, standard operating procedures and batches from the same or different harvest lots or process lots of cannabinoid concentrate or extract.

(34) "Producer" means a person:

(a) Licensed by the Commission to produce marijuana under ORS 475B.070; and

(b) Registered with the Authority under ORS 475B.420 as a grower and who is not exempt from labeling requirements under ORS 475B.605.

(35) "Product identity" means a truthful or common name of the product that is contained in the package.

(36) "Registrant" means a person registered with the Authority under ORS 475B.400 to 475B.525.

(37) "Registry identification cardholder" means a person to whom a registration card has been issued under ORS 475B.415.

(38)(a) "Test batch" means a group of test samples that are collectively submitted to a laboratory for testing purposes.

(b) "Test batch" does not mean a combination of marijuana flowers, marijuana leaves, cannabinoid products, or cannabinoid concentrate or extract.

(39) "Test sample" means anything collected by an individual authorized by the Authority to collect a sample from a licensee or registrant that is provided to a laboratory for testing, including but not limited to marijuana items, soil, growing medium, water, solvent or swab of a counter or equipment.

(40) "THC" means tetrahydrocannabinol and has the same meaning as delta-9 THC.

(41) "These rules" means OAR 333-007-0010 through 333-007-0100.

(42) "Universal symbol" means the image, established by the Authority and made available to licensees and registrants, indicating the marijuana item contains marijuana.

(43)(a) "Usable marijuana" means the dried leaves and flowers of marijuana.

(b) "Usable marijuana" does not include:

(A) The seeds, stalks and roots of marijuana; or

(B) Waste material that is a by-product of producing or processing marijuana.

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0030
Marijuana Plant Labeling Requirements

Prior to a marijuana plant being sold or transferred to a consumer, patient or designated primary caregiver a tag or label must be affixed to the plant or plant container that has the following information:

(1) Producer's business or trade name and licensee or registrant number;

(2) Business or trade name of licensee or registrant that packaged or distributed the product, if different from the producer;

(3) Name of the strain; and

(4) Universal symbol.

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0040
Marijuana Seed Labeling Requirements

Prior to a marijuana plant being sold or transferred to a consumer, patient or designated primary caregiver a tag or label must be affixed to the plant or plant container that has the following information:

(1) Producer's business or trade name and licensee or registrant number;

(2) Business or trade name of licensee or registrant that packaged or distributed the product, if different from the producer;

(3) Name of the strain; and

(4) Universal symbol.

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0050
Usable Marijuana Labeling Requirements

Prior to usable marijuana being sold or transferred to a consumer, patient or designated primary caregiver the container holding the usable marijuana must have a label that has the following information:

(1) Producer's business or trade name and licensee or registrant number;

(2) Business or trade name of licensee or registrant that packaged or distributed the product, if different from the producer;

(3) For licensees, package unique identification number and for registrants, harvest lot number;

(4) Date of harvest;

(5) Name of strain;

(6) Net weight in U.S. customary and metric units;

(7) Concentration of THC and CBD, as calculated under OAR 333-064-0100;

(8) Activation time expressed in words or through a pictogram;

(9) Name of the lab that performed any test, any associated test batch number and any test analysis date;

(10) Universal symbol;

(11) For usable marijuana for sale to a consumer warnings that state:

(a) "For use by adults 21 and older. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

(12) For usable marijuana for use by a patient warnings that state:

(a) "For use by OMMP patients only. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0060
Cannabinoid Topical Labeling Requirements

Prior to a cannabinoid topical product being sold or transferred to a consumer, patient or designated primary caregiver the container holding the cannabinoid product must have a label that has the following information:

(1) Processor's business or trade name and licensee or registrant number;

(2) Business or trade name of licensee or registrant that packaged or distributed the product, if different from the processor;

(3) For licensees, package unique identification number and for registrants, process lot number;

(4) Product identity (common or usual name);

(5) Date the product was made;

(6) Net weight or volume in U.S. customary and metric units;

(7) Amount suggested for use by the consumer or patient at any one time;

(8) Concentration or amount by weight or volume of THC and CBD in the container;

(9) List of ingredients in descending order or predominance by weight or volume used to process the cannabinoid topical;

(10) Activation time, expressed in words or through a pictogram;

(11) Name of the lab that performed any test, any associated test batch number and any test analysis date;

(12) Universal symbol;

(13) For licensees, a medical grade symbol if applicable;

(14) A statement that reads: "This product is not approved by the FDA to treat, cure, or prevent any disease";

(15) For cannabinoid topicals for sale to a consumer warnings that state:

(a) "For use only by adults 21 and older. Keep out of reach of children."

(b) "DO NOT EAT" in bold, capital letters.

(16) For cannabinoid topicals for use by a patient warnings that state:

(a) "For use by OMMP patients only. Keep out of reach of children."

(b) "DO NOT EAT" in bold, capital letters.

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0070
Cannabinoid Edible Labeling Requirements

Prior to a cannabinoid edible being sold or transferred to a consumer, patient or designated primary caregiver the container holding the edible must have a label that has the following information:

(1) Processor's business or trade name, place of address, and licensee or registrant number;

(2) Business or trade name and place of address of licensee or registrant that packaged or distributed the product, if different from the processor;

(3) Product identity (common or usual name);

(4) For licensees, package unique identification number and for registrants, process lot number;

(5) Date the edible was made;

(6) Net weight or volume in U.S. customary and metric units;

(7) Serving size and number of servings per container;

(8) Concentration or amount by weight or volume of THC and CBD in each serving and in each container;

(9) List of all ingredients in descending order of predominance by weight or volume used to process the cannabinoid edible;

(10) List of potential major food allergens:

(a) Using a "contains" statement to summarize the major food allergen information at the end of or immediately adjacent to the ingredient list; or

(b) Placing the term for the appropriate major food allergen in parenthesis within the ingredient list after the common or usual name of the ingredient derived from that major food allergen;

(11) The amount, in grams, of sodium, sugar, carbohydrates and total fat per serving;

(12) If the edible is perishable, a statement that the edible must be refrigerated or kept frozen;

(13) Name of the lab that performed any test, any associated test batch number and any test analysis date;

(14) Activation time, expressed in words or through a pictogram;

(15) Universal symbol;

(16) For licensees, a medical grade symbol if applicable;

(17) A statement that reads: "This product is not approved by the FDA to treat, cure, or prevent any disease";

(18) For cannabinoid edibles for sale to a consumer warnings that state:

(a) "For use only by adults 21 and older. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

(c) "BE CAUTIOUS" in bold, capital letters, followed by "Cannabinoid edibles can take up to 2 hours or more to take effect."

(19) For cannabinoid edibles for use by a patient warnings that state:

(a) "For use by OMMP patients only. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

(c) "BE CAUTIOUS" in bold, capital letters, followed by "Cannabinoid edibles can take up to 2 hours or more to take effect."

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0080
Labeling Requirements for Cannabinoid Concentrates and Extracts

Prior to a cannabinoid concentrate or extract being sold or transferred to a consumer, patient or designated primary caregiver the container holding the concentrate or extract must have a label that has the following information:

(1) Processor's business or trade name and licensee or registrant number;

(2) Business or trade name of licensee or registrant that packaged or distributed the product, if different from the processor;

(3) For licensees, package unique identification number and for registrants, process lot number;

(4) Product identity (concentrate or extract);

(5) Date the concentrate or extract was made;

(6) Net weight or volume in U.S. customary and metric units;

(7) If applicable, serving size and number of servings per container or amount suggested for use by the consumer or patient at any one time;

(8) Concentration or amount by weight or volume of THC and CBD in each amount suggested for use and in the container;

(9) Activation time, expressed in words or through a pictogram;

(10) Name of the lab that performed any test, any associated test batch number and any test analysis date;

(11) Universal symbol;

(12) For licensees, a medical grade symbol if applicable;

(13) A statement that reads: "This product is not approved by the FDA to treat, cure, or prevent any disease";

(14) For cannabinoid concentrates and extracts for sale to a consumer warnings that state:

(a) "For use only by adults 21 and older. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

(c) "DO NOT EAT" in bold, capital letters.

(15) For cannabinoid concentrates and extracts for use by a patient warnings that state:

(a) "For use by OMMP patients only. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

(c) "DO NOT EAT" in bold, capital letters.

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0083
Cannabinoid Tincture Labeling Requirements

Prior to a cannabinoid tincture being sold or transferred to a consumer, patient or designated primary caregiver the container holding the tincture must have a label that has the following information:

(1) Processor's business or trade name, place of address and licensee or registrant number;

(2) Business or trade name and place of address of licensee or registrant that packaged or distributed the product, if different from the processor;

(3) Product identity (common or usual name);

(4) For licensees, package unique identification number and for registrants, process lot number;

(5) Date the tincture was made;

(6) Net weight or volume in U.S. customary and metric units;

(7) Serving size and number of servings per container;

(8) Concentration or amount by weight or volume of THC and CBD in each serving and in each container;

(9) List of all ingredients in descending order of predominance by weight or volume used to process the cannabinoid tincture;

(10) Name of the lab that performed any test, any associated test batch number and any test analysis date;

(11) Universal symbol;

(12) For licensees, a medical grade symbol if applicable;

(13) Activation time expressed in words or through a pictogram;

(14) A statement that reads: "This product is not approved by the FDA to treat, cure, or prevent any disease";

(15) For cannabinoid tinctures for sale to a consumer warnings that state:

(a) "For use only by adults 21 and older. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

(16) For cannabinoid tinctures for use by a patient warnings that state:

(a) "For use by OMMP patients only. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0085
Cannabinoid Products Other than Cannabinoid Edibles, Topicals, or Tinctures

Prior to a cannabinoid product other than a cannabinoid edible, topical or tincture being sold or transferred to a consumer, patient or designated primary caregiver the container holding the product must have a label that has the following information:

(1) Processor's business or trade name and licensee or registrant number;

(2) Business or trade name of licensee or registrant that packaged or distributed the product, if different from the processor;

(3) Place of address for the processor and packager, if applicable;

(4) Product identity (common or usual name);

(5) For licensees, package unique identification number and for registrants, process lot number;

(6) Date the product was made;

(7) Net weight or volume in U.S. customary and metric units;

(8) Serving size and number of servings per container;

(9) Concentration or amount by weight or volume of THC and CBD in each serving and in each container;

(10) List of all ingredients in descending order of predominance by weight or volume used to process the cannabinoid product;

(11) Name of the lab that performed any test, any associated test batch number and any test analysis date;

(12) Universal symbol;

(13) For licensees, a medical grade symbol if applicable;

(14) Activation time expressed in words or through a pictogram;

(15) A statement that reads: "This product is not approved by the FDA to treat, cure, or prevent any disease";

(16) For cannabinoid products for sale to a consumer warnings that state:

(a) "For use only by adults 21 and older. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

(17) For cannabinoid products for use by a patient warnings that state:

(a) "For use by OMMP patients only. Keep out of reach of children."

(b) "It is illegal to drive a motor vehicle while under the influence of marijuana."

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0090
General Label Requirements; Prohibitions; Exceptions

(1) Principal Display Panel.

(a) Every container that contains a marijuana item for sale or transfer to a consumer, patient or designated primary caregiver must have a principal display panel, as that term is defined in OAR 333-007-0020.

(b) If a container is placed within packaging for purposes of displaying the marijuana item for sale or transfer to a consumer, patient or designated primary caregiver, the packaging must have a principal display panel as that term is defined in OAR 333-007-0020.

(c) The principal display panel must contain the product identity, net weight, and universal symbol, if applicable.

(d) If the product is a medical grade cannabinoid product, concentrate or extract processed by a licensee the principal display panel must include the medical grade symbol.

(2) A label required by these rules must:

(a) Be placed on the container and on any packaging that is used to display the marijuana item for sale or transfer to a consumer, patient or designated primary caregiver.

(b) Comply with the National Institute of Standards and Technology (NIST) Handbook 130 (2016), Uniform Packaging and Labeling Regulation, incorporated by reference.

(c) Be in no smaller than 8 point Times New Roman, Helvetica or Arial font;

(d) Be in English, though it can be in other languages; and

(e) Be unobstructed and conspicuous.

(3) A marijuana item may have one or more labels affixed to the container or packaging.

(4) A marijuana item that is in a container that because of its size does not have sufficient space for a label that contains all the information required for compliance with these rules:

(a) May have a label on the container that contains a marijuana item and on any packaging that is used to display the marijuana item for sale or transfer to a consumer, patient or designated primary caregiver that includes at least the following:

(A) Information required on a principal display panel, if applicable for the type of marijuana item;

(B) Licensee or registrant business or trade name and licensee or registrant number;

(C) For licensees, package unique identification number and for registrants, batch or process lot number;

(D) Concentration of THC and CBD; and

(E) Required warnings; and

(b) Must include all other required label information not listed in subsection (4)(a) of this rule on an outer container or package, or on a leaflet that accompanies the marijuana item.

(5) A marijuana item in a container that is placed in packaging that is used to display the marijuana item for sale or transfer to a consumer, patient, or designated primary caregiver must comply with the labeling requirements in these rules, even if the container qualifies for the exception under section (4) of this rule.

(6) The universal symbol:

(a) Must be at least 0.48 inches wide by 0.35 inches high.

(b) May only be used by licensees or registrants.

(c) May be downloaded at www.healthoregon.org/marijuana.

(7) Medical grade symbol. The medical grade symbol must be at least 0.35 inches in diameter.

(8) A label may not:

(a) Contain any untruthful or misleading statements including, but not limited to, a health claim that is not supported by the totality of publicly available scientific evidence (including evidence from well-designed studies conducted in a manner which is consistent with generally recognized scientific procedures and principles), and for which there is significant scientific agreement, among experts qualified by scientific training and experience to evaluate such claims; or

(b) Be attractive to minors, as that is defined in OAR 845-025-7000.

(9) A marijuana item that falls within more than one category, for example a product that is both a cannabinoid concentrate and cannabinoid edible, must comply with the labeling requirements that apply to both categories, with the exception of the "DO NOT EAT" warning if the product is intended for human consumption or the "BE CAUTIOUS" warning if the effects of the product are customarily felt immediately.

(10) The THC and CBD amount required to be on a label must be the value calculated by the laboratory that did the testing in accordance with OAR 333-064-0100.

(11) If a marijuana item has more than one test batch number, laboratory, or test analysis date associated with the marijuana item that is being sold or transferred, each test batch number, laboratory and test analysis date must be included on a label.

(12) If a marijuana item is placed in a package that is being re-used, the old label or labels must be removed and it must have a new label or labels.

(13) A licensee or registrant must have documentation that demonstrates the validity of the calculation of the amount of sodium, sugar, carbohydrates and total fat in a cannabinoid edible and must make that documentation available to the Commission or the Authority upon request.

(14) Exit packaging must contain a label that reads: "Keep out of the reach of children."

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0100
Pre-Approval of Labels

(1) A registrant must submit labels for pre-approval in accordance with OAR 845-025-7060 and must keep all records related to the pre-approval process and provide those records at the request of the Authority.

(2) On and after October 1, 2016, a registrant may not transfer a marijuana item unless the label has been pre-approved in accordance with OAR 845-025-7060.

Stat. Auth.: ORS 475B.605
Stats. Implemented: ORS 475B.605
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0200
Definitions, Purpose, Scope, Effective Date

(1) In accordance with ORS 475B.625, the Authority must establish, for marijuana items sold or transferred to a consumer, patient or designated primary caregiver through a Commission licensed marijuana retailer or medical marijuana dispensary:

(a) The maximum concentration of THC permitted in a single serving of a cannabinoid product or cannabinoid concentrate or extract; and

(b) The number of servings permitted in a cannabinoid product container or cannabinoid concentrate or extract container.

(2) The concentration of THC permitted under OAR 333-007-0210 through 333-007-0220 must take into account both the amount of Delta-9 THC in the cannabinoid product or cannabinoid concentrate or extract and the amount of tetrahydrocannabinolic acid (THCA) in the cannabinoid product or cannabinoid concentrate or extract that if heated would convert THCA to THC. A cannabinoid product or cannabinoid concentrate or extract that contains a high amount of THCA must meet the concentration limits established in OAR 333-007-0200 through 333-007-0220 even if heated.

(3) The amounts of THC listed on a label are based on an average from samples taken from a harvest or process lot and may not represent the exact amount of THC in a marijuana item purchased by a consumer, patient or designated primary caregiver.

(4) On and after October 1, 2016:

(a) A marijuana item received or transferred by a dispensary must meet the concentration and serving size limits in OAR 333-007-0210 or 333-007-0220, depending on whether the marijuana is available for sale or transfer to a consumer, patient or designated primary caregiver; and

(b) A dispensary may not receive or transfer a marijuana item that does not meet the concentration and serving size limits in OAR 333-007-0210 or 333-007-0220, as applicable.

(5) By October 1, 2016, a dispensary must have either transferred marijuana items that do not meet the concentration and serving size limits in OAR 333-007-0210 or 333-007-0220 to a patient or caregiver or must have returned any marijuana item that does not meet the requirements to the individual who transferred the item to the dispensary, and must document who the item was returned to, what was returned and the amount, and the date of the return.

(6) For purposes of OAR 333-007-0200 through 333-007-0220:

(a) The definitions in OAR 333-007-0020 apply unless otherwise specified.

(b) "Cannabinoid capsule" means a small soluble container, usually made of gelatin, that encloses a dose of a cannabinoid product, concentrate or extract intended for human ingestion.

(c) "Cannabinoid edible" means a food or potable liquid into which a cannabinoid concentrate or extract or the dried leaves or flowers of marijuana have been incorporated.

(d) "Cannabinoid suppository" means a small soluble container designed to melt at body temperature within a body cavity other than the mouth, especially the rectum or vagina containing a cannabinoid product, concentrate or extract.

(e) "Cannabinoid transdermal patch" means an adhesive substance applied to human skin that contains a cannabinoid product, concentrate or extract for absorption into the bloodstream.

(f) "Medical marijuana item" is a marijuana item for sale or transfer to a patient or designated primary caregiver and includes medical grade cannabinoid products, cannabinoid concentrates and cannabinoid extracts.

(g) "Retail adult use marijuana item" is a marijuana item for sale to a consumer.

(h) "Scored" means to physically demark a cannabinoid edible in a way that enables a reasonable person to:

(A) Intuitively determine how much of the product constitutes a single serving; and

(B) Easily physically separate the edible into single servings either by hand or with a common utensil, such as a knife.

Stat. Auth.: ORS 475B.625
Stats. Implemented: ORS 475B.625
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0210
Retail Marijuana Item Concentration and Serving Size Limits

(1) The maximum concentration or amount of THC permitted in a container and the maximum concentration or amount of THC permitted in a serving of a retail adult use marijuana item is listed in Table 1. [Table not included. See ED. NOTE.]

(2) A cannabinoid edible must be scored unless it is not capable of being scored because it is not solid at room temperature in which case the cannabinoid edible must be:

(a) Sold and packaged with a measuring device that measures single servings; or

(b) Placed in packaging that clearly enables a consumer to determine when a single serving has been consumed.

(3) Serving size is as determined by the processor.

(4) A retail adult use marijuana item that does not fall within a category in Table 1 such as cannabinoid suppositories and transdermal patches must meet the concentration and serving size limits applicable to a cannabinoid edible in Table 1.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: Sec. 105, ch. 614, OL 2015
Stats. Implemented: Sec. 105, ch. 614, OL 2015
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0220
Medical Marijuana Item Concentration Limits

(1) The maximum concentration or amount of THC permitted in a container and the maximum concentration or amount of THC permitted in a serving of a medical marijuana item is listed in Table 2. [Table not included. See ED. NOTE.]

(2) A cannabinoid edible must be scored unless it is not capable of being scored because of its form or because it is not solid at room temperature in which case the cannabinoid edible must be:

(a) Sold and packaged with a measuring device that measures single servings; or

(b) Placed in packaging that clearly enables a patient to determine when a single serving has been consumed, as that serving size is determined by the processor.

(3) Serving size is as determined by the processor.

(4) A medical marijuana item that does not fall within a category in Table 2 must meet the concentration and serving size limits applicable to a cannabinoid edible in Table 2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: Sec 105, ch 614, OL 2015
Stats. Implemented: Sec 105, ch 614, OL 2015
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0300
Purpose and Effective Date

(1) The purpose of these rules is to establish the minimum testing standards for marijuana items. These rules are applicable to:

(a) A licensee; and

(b) A registrant who is not exempt from the testing requirements.

(2) The testing requirements do not apply to:

(a) A grower if the person is transferring usable marijuana or an immature marijuana plant to:

(A) A patient who designated the grower to grow marijuana for the patient; or

(B) A designated primary caregiver of the patient who designated the grower to grow marijuana for the patient; or

(b) A designated primary caregiver of a patient if the caregiver is transferring a marijuana item to a patient of the designated primary caregiver.

(3) A person registered with the Authority under ORS 475B.400 to 475B.525 who is subject to these rules may not:

(a) Transfer a marijuana item on or after October 1, 2016, that is not sampled and tested in accordance with these rules; or

(b) Accept the transfer of a marijuana item on or after October 1, 2016, that is not sampled and tested in accordance with these rules.

(4) A person licensed by the Commission must comply with these rules at all times.

(5) Notwithstanding section (3)(a) of this rule, until January 1, 2017, a dispensary may transfer a marijuana item to a patient or caregiver that was transferred to the dispensary before October 1, 2016, and that was not sampled and tested in accordance with these rules if the item contains a label placed on the package where it can easily be seen by the patient or caregiver that reads "DOES NOT MEET NEW TESTING REQUIREMENTS" in 12 point font, and in bold, capital letters.

(6) Nothing in these rules prevents a registrant from having marijuana items sampled and tested in accordance with these rules by an accredited and licensed laboratory prior to October 1, 2016.

(7) Prior to October 1, 2016, an accredited laboratory performing sampling or testing for a registrant may comply with this rule or OAR 333-008-1190 but the laboratory must identify on the test result which rule the results are compliant with.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0310
Definitions

For purposes of OAR 333-007-0300 through 333-007-0490:

(1) "Authority" means the Oregon Health Authority.

(2) "Batch" means:

(a) A quantity of usable marijuana from a harvest lot; or

(b) A quantity of cannabinoid concentrate or extract or cannabinoid product from a process lot.

(3) "Cannabinoid" means any of the chemical compounds that are the active constituents of marijuana.

(4) "Cannabinoid concentrate or extract" means a substance obtained by separating cannabinoids from marijuana by a mechanical, chemical or other process.

(5) "Cannabinoid edible" means food or potable liquid into which a cannabinoid concentrate or extract or the dried leaves or flowers of marijuana have been incorporated.

(6)(a) "Cannabinoid product" means a cannabinoid edible or any other product intended for human consumption or use, including a product intended to be applied to a person's skin or hair, that contains cannabinoids or the dried leaves or flowers of marijuana.

(b) "Cannabinoid product" does not include:

(A) Usable marijuana by itself;

(B) A cannabinoid concentrate or extract by itself; or

(C) Industrial hemp, as defined in ORS 571.300.

(7) "Cannabinoid capsule":

(a) Means a small soluble container, usually made of gelatin that encloses a dose of a cannabinoid product, concentrate or extract intended for human ingestion.

(b) Does not mean a cannabinoid suppository.

(8) "Cannabinoid suppository" means a small soluble container designed to melt at body temperature within a body cavity other than the mouth, especially the rectum or vagina containing a cannabinoid product, concentrate or extract.

(9) "Cannabinoid tincture" means a solution of alcohol, cannabinoid concentrate or extract, and perhaps other ingredients intended for human consumption or ingestion, and that is exempt from the Liquor Control Act under ORS 471.035.

(10) "Cannabinoid topical" means a cannabinoid product intended to be applied to skin or hair and for purposes of testing includes transdermal patches.

(11) Cannabinoid Transdermal patch" means an adhesive substance applied to human skin that contains a cannabinoid product, concentrate or extract for absorption into the bloodstream.

(12) "CBD" means cannabidiol, Chemical Abstracts Service Number 13956-29-1.

(13) "CBDA" means cannabidiolic acid, Chemical Abstracts Service Number 1244-58-2.

(14) "Chain of custody procedures" means procedures employed by laboratory personnel using a chain of custody form to record the possession of samples from the time of sampling through the retention time specified by the Authority or Commission.

(15) "Chain of custody form" means a form completed by laboratory personnel that documents the collection, transport, and receipt of samples by the laboratory.

(16) "Commission" means the Oregon Liquor Control Commission.

(17) "Consumer" has the meaning given that term in ORS 475B.015 and does not include a patient or designated primary caregiver.

(18) "Delta-9 THC" is the principal psychoactive constituent (the principal cannabinoid) of cannabis, Chemical Abstracts Service Number 1972-08-3.

(19)(a) "Designated primary caregiver" means an individual 18 years of age or older who has significant responsibility for managing the well-

being of a person who has been diagnosed with a debilitating medical condition, who is designated as such on that person's application for a registry identification card or in other written notification to the Authority, and who has been issued an identification card by the Authority under ORS 475B.415(5)(b).

(b) "Designated primary caregiver" does not include the person's attending physician.

(20) "Field duplicate sample" means a sample taken in an identical manner from and representative of the same marijuana item being sampled that is analyzed separately, that is used for quality control only.

(21) "Food" means a raw, cooked, or processed edible substance, or ingredient used or intended for use or for sale in whole or in part for human consumption, or chewing gum.

(22) "Grower" has the same meaning as "person responsible for a marijuana grow site."

(23) "Grow site" means a specific location registered by the Authority and used by the grower to produce marijuana for medical use by a specific patient under ORS 475B.420.

(24) "Harvest lot " means a specifically identified quantity of marijuana that is uniform in strain, cultivated utilizing the same growing practices, harvested at the same time at the same location and cured under uniform conditions.

(25) "Homogeneous" means a cannabinoid product, concentrate or extract has uniform composition and properties throughout each process lot.

(26) "Human consumption or human ingestion" means to ingest, generally through the mouth, food, drink or other substances such that the substance enters the human body but does not include inhalation.

(27) "Laboratory" means a laboratory that is accredited under ORS 438.605 to 438.620 to sample or conduct tests on marijuana items and licensed by the Oregon Liquor Control Commission under ORS 475B.560.

(28) "Licensee" has the meaning given that term in ORS 475B.015.

(29)(a) "Marijuana" means the plant Cannabis family Cannabaceae, any part of the plant Cannabis family Cannabaceae and the seeds of the plant Cannabis family Cannabaceae.

(b) "Marijuana" does not include industrial hemp, as defined in ORS 571.300.

(30) "Marijuana item" means marijuana, usable marijuana, a cannabinoid product or a cannabinoid concentrate or extract.

(31) "Marijuana processing site" means a marijuana processing site registered under ORS 475B.435.

(32) "Medical marijuana dispensary" or "dispensary" means a medical marijuana dispensary registered under ORS 475B.450.

(33) "ORELAP" means the Oregon Environmental Laboratory Accreditation Program administered by the Authority pursuant to ORS 438.605 to 438.620.

(34) "Patient" has the same meaning as "registry identification cardholder."

(35) "Person responsible for a marijuana grow site" has the same meaning as "grower" and means a person who has been selected by a patient to produce medical marijuana for the patient and who has been registered by the Authority for this purpose under ORS 475B.420.

(36) "Process lot" means:

(a) Any amount of cannabinoid concentrate or extract of the same type and processed using the same extraction methods, standard operating procedures and batches from the same or a different harvest lot; or

(b) Any amount of a cannabinoid product of the same type and processed using the same ingredients, standard operating procedures and batches from the same or a different harvest lot or process lot of cannabinoid concentrate or extract as defined in subsection (a) of this section.

(37) "Process validation" means a study performed on products or matrices of unknown homogeneity to assure required uniformity of product accomplished through a series of sampling and testing from three consecutive process lots as described in OAR 333-007-0440.

(38) "Processing" means the compounding or conversion of marijuana into cannabinoid products or cannabinoid concentrates or extracts.

(39) "Processing site" means a processor registered with Authority under ORS 475B.435.

(40) "Processor" has the meaning given that term in OAR 845-025-1015.

(41) "Producer" has the meaning given that term in OAR 845-025-1015.

(42) "Producing" means:

(a) Planting, cultivating, growing, trimming or harvesting marijuana; or

(b) Drying marijuana leaves and flowers.

(43) "Registrant" means a grower, marijuana processing site, or a medical marijuana dispensary registered with the Authority under ORS 475B.420, 475B.435 or 475B.450.

(44) "Registry identification cardholder" means a person who has been diagnosed by an attending physician with a debilitating medical condition and for whom the use of medical marijuana may mitigate the symptoms or effects of the person's debilitating medical condition, and who has been issued a registry identification card by the Authority under ORS 475B.415(5)(a).

(45) "Relative percentage difference" or "RPD" means the comparison of two quantities while taking into account the size of what is being compared as calculated under OAR 333-064-0100..

(46) "Relative standard deviation" or "RSD" means the standard deviation expressed as a percentage of the mean recovery as calculated under OAR 333-064-0100.

(47) "Sample" means an amount of a marijuana item collected by laboratory personnel from a registrant or licensee and provided to a laboratory for testing.

(48) "Sterilization" means the removal of all microorganisms and other pathogens from a marijuana item by treating it with approved chemicals or subjecting it to high heat.

(49) "Test batch" means a group of samples from a batch submitted collectively to a laboratory for testing purposes.

(50) "THC" means tetrahydrocannabinol and has the same Chemical Abstracts Service Number as delta-9 THC.

(51) "THCA" means tetrahydrocannabinolic acid, Chemical Abstracts Service Number 23978-85-0.

(52) "These rules" means OAR 333-007-0300 through 333-007-0490.

(53) "TNI" means The NELAC (National Environmental Laboratory Accreditation Conference) Institute, a voluntary organization of state and federal environmental officials and interest groups purposed primarily to establish consensus standards for accrediting environmental laboratories.

(54) "TNI EL Standards" means the adopted 2009 TNI Environmental Lab Standards (© 2009 The NELAC Institute), which describe the elements of laboratory accreditation developed and established by the consensus principles of TNI and that meet the approval requirements of TNI procedures and policies.

(55) "Total THC" means the molar sum of THC and THCA.

(56)(a) "Usable marijuana" means the dried leaves and flowers of marijuana.

(b) "Usable marijuana" does not include:

(A) The seeds, stalks and roots of marijuana; or

(B) Waste material that is a by-product of producing or processing marijuana.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0315
Ordering Tests

A registrant or licensee must provide a laboratory, prior to laboratory taking samples, with the following:

(1) A written request of analysis for each test the laboratory is being requested to conduct.

(2) Notification of whether the batch is being re-sampled because of a failed test and the failed test results.

(3) Certification of successful process validation, if applicable, on a form prescribed by the Authority.

(4) Proof of a waiver under OAR 333-007-0490, if applicable.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0320
Testing Requirements for Marijuana or Usable Marijuana

(1) A producer or grower must test every harvest lot of marijuana or usable marijuana intended for use by a consumer or patient prior to selling or transferring the marijuana or usable marijuana for the following:

(a) Pesticides in accordance with OAR 333-007-0400.

(b) Water activity and moisture content in accordance with OAR 333-007-0420.

(c) THC and CBD concentration in accordance with OAR 333-007-0430.

(2) A producer or grower must test every harvest lot of marijuana or usable marijuana intended for use by a processor or processing site for water activity and moisture content in accordance with OAR 333-007-0420 unless the processor or processing site uses a method of processing that results in effective sterilization.

(3) A producer or grower must test a harvest lot of marijuana or usable marijuana for microbiological contaminants in accordance with OAR 333-007-0390, upon written request by the Authority or the Commission.

(4) In lieu of ordering and arranging for the sampling and testing required in this rule a producer may transport batches of marijuana or usable marijuana to a wholesaler licensed by the Commission under ORS 475B.100 and the wholesaler may order and arrange for the sampling and testing of the batches, in accordance with rules established by the Commission.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0330
Testing Requirements for Cannabinoid Concentrates and Extracts

(1) A processor or processing site must test every process lot of cannabinoid concentrate or extract for use by a consumer or patient prior to selling or transferring the cannabinoid concentrate or extract for the following:

(a) Pesticides in accordance with OAR 333-007-0400.

(b) Solvents in accordance with OAR 333-007-0410.

(c) THC and CBD concentration in accordance with OAR 333-007-0430.

(2) A processor or processing site must test every process lot of a cannabinoid concentrate or extract intended for use by a processor or processing site to make a cannabinoid product for the following:

(a) Pesticides in accordance with OAR 333-007-0400.

(b) Solvents in accordance with OAR 333-007-0410.

(3) A processor or processing site is exempt from testing for solvents under this rule if the processor or processing site:

(a) Did not use any solvent listed in OAR 333-007-0410, Table 4; and

(b) Only used a mechanical extraction process to separate cannabinoids from the marijuana; or

(c) Used only water, animal fat or vegetable oil as a solvent to separate the cannabinoids from the marijuana.

(4) A processor or processing site must test a process lot of a cannabinoid concentrate or extract for microbiological contaminants in accordance with OAR 333-007-0390, upon written request by the Authority or the Commission.

(5) In lieu of ordering and arranging for the sampling and testing required in this rule a processor may transport batches of cannabinoid concentrates or extracts to a wholesaler licensed by the Commission under ORS 475B.100 and the wholesaler may order and arrange for the sampling and testing of the batches, in accordance with rules established by the Commission.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0340
Testing Requirements for Cannabinoid Products Intended for Human Consumption or Ingestion and Cannabinoid Suppositories

(1) A processor or processing site must test every process lot of a cannabinoid product intended for human consumption or ingestion, including cannabinoid edibles, capsules, and tinctures, and cannabinoid suppositories for use by a consumer or patient prior to selling or transferring the cannabinoid product for THC and CBD concentration in accordance with OAR 333-007-0430.

(2) A processor or processing site must test a process lot for microbiological contaminants in accordance with OAR 333-007-0390, upon written request by the Authority or the Commission.

(3) In lieu of ordering and arranging for the sampling and testing required in this rule a processor may transport batches of cannabinoid products references in section (1) of this rule to a wholesaler licensed by the Commission under ORS 475B.100 and the wholesaler may order and arrange for the sampling and testing of the batches, in accordance with rules established by the Commission.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0345
Testing Requirements for Cannabinoid Topicals and Cannabinoid Transdermal Patches

(1) A processor or processing site must test every process lot of a cannabinoid topical or transdermal patch for use by a consumer or patient prior to selling or transferring the cannabinoid product for THC and CBD concentration in accordance with OAR 333-007-0430.

(2) A processor or processing site must test a process lot of a cannabinoid topical or transdermal patch for microbiological contaminants in accordance with OAR 333-007-0390, upon written request by the Authority or the Commission.

(3) In lieu of ordering and arranging for the sampling and testing required in this rule a processor may transport batches of cannabinoid products references in section (1) of this rule to a wholesaler licensed by the Commission under ORS 475B.100 and the wholesaler may order and arrange for the sampling and testing of the batches, in accordance with rules established by the Commission.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0350
Batch Size

(1) Usable marijuana.

(a) A producer or grower must separate each harvest lot into no larger than 10 pound batches.

(b) Notwithstanding subsection (1)(a) of this rule, a producer or grower may combine harvest lots together for purposes of having a batch sampled if each batch is intended for use by a processor or processing site to make a cannabinoid concentrate or extract and each harvest lot was:

(A) Cultivated utilizing the same growing practices and grown in close proximity on the licensed or registered premises;

(B) Harvested at the same time; and

(C) If cured prior to sampling, cured under uniform conditions.

(c) A producer or grower may not combine harvest lots into a batch for purposes of sampling and testing for THC or CBD.

(d) If harvest lots are combined in accordance with subsection (1)(b) of this rule the batch must be labeled so that it identifies the different harvest lots that were combined.

(2) Cannabinoid concentrates and extracts and cannabinoid products. A process lot is considered a batch.

(3) A grower and processing site must assign each batch a unique batch number and that unique batch number must be:

(a) Documented and maintained in the grower and processing site records for at least two years and available to the Authority upon request;

(b) Provided to the individual responsible for taking samples; and

(c) Included on the batch label as required in OAR 333-007-0380.

(4) A grower and processing site may not reuse a unique batch number.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0360
Sampling and Sample Size

(1) Usable marijuana.

(a) Usable marijuana may only be sampled after it is cured, unless the usable marijuana is intended for sale or transfer to a processor or processing site to make a cannabinoid concentrate or extract.

(b) Samples taken must in total represent a minimum of 0.5 percent of the batch, consistent with the laboratory's accredited sampling policies and procedures, described in OAR 333-064-0100(2).

(2) Cannabinoid concentrates, extracts and products.

(a) Unless a cannabinoid concentrate, extract or product has successfully passed process validation, enough samples from a batch must be taken to ensure that the required attributes in the batch to be tested are homogenous and consistent with the laboratory's accredited sampling policies and procedures described in OR 333-064-0100(2).

(b) If a cannabinoid concentrate, extract or product has successfully passed process validation only a primary sample and field duplicate sample must be taken from a batch in accordance with the laboratory's accredited sampling policies and procedures described in OAR 333-064-0100(2).

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0370
Sampling Personnel Requirements; Sampling Recordkeeping

(1) Only individuals employed by a laboratory with an ORELAP accredited scope item for sampling under these rules may take samples.

(2) Sampling may be conducted at a licensee's or registrant's premises or the licensee or registrant may transport the batch to a laboratory with an ORELAP accredited scope item for sampling under these rules.

(3) Laboratory personnel that perform sampling must:

(a) Follow the laboratory's accredited sampling policies and procedures;

(b) Follow chain of custody procedures consistent with TNI EL Standard V1M2 5.7 and 5.8; and

(c) After taking samples document the samples in accordance with OAR 333-064-0100(2) and if sampling for a licensee record the sampling and transfer information in the Commission's seed to sale system, as required by the Commission.

(4) A laboratory must maintain the documentation required in these rules for at least two years and must provide that information to the Authority upon request.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0380
Grower and Processing Site Requirements for Labeling, Storing, and Securing Pre-Tested Marijuana Items; Recordkeeping

(1) Following samples being taken from a harvest or process lot batch a grower or processing site must:

(a) Label the batch with the following information:

(A) The registrant's registration number;

(B) The harvest or process lot unique identification number;

(C) The name and accreditation number of the laboratory that took samples and the name and accreditation number of the laboratory responsible for the testing, if different;

(D) The test batch or sample unique identification numbers supplied by the laboratory personnel;

(E) The date the samples were taken; and

(F) In bold, capital letters, no smaller than 12 point font, "PRODUCT NOT TESTED."

(b) Store and secure the batch in a manner that prevents the product from being tampered with or transferred prior to test results being reported.

(c) Be able to easily locate a batch stored and secured under section (1)(b) of this rule and provide that location to the Authority or a laboratory upon request.

(2) If the samples pass testing the product may be sold or transferred in accordance with the applicable Authority rules.

(3) If the samples do not pass testing the grower or processing site must comply with OAR 333-007-0450.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0390
Standards for Testing Microbiological Contaminants

(1) A marijuana item required to be tested for microbiological contaminants must be sampled using appropriate aseptic technique and tested by a laboratory for total coliform count.

(2) If a laboratory detects the presence of any coliforms the sample must be assessed for Escherichia coli (E. coli).

(3) A batch fails microbiological contaminant testing if the laboratory detects the presence of E. coli at more than 100 colony forming units per gram in a sample:

(a) During an initial test where no reanalysis is requested; or

(b) Upon reanalysis as described in OAR 333-007-0450(1).

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0400
Standards for Testing Pesticides

(1) A marijuana item required to be tested for pesticides must be tested by a laboratory for the analytes listed in Exhibit A, Table 3, incorporated by reference. [Table not included. See ED. NOTE.]

(2) A batch fails pesticide testing if a laboratory detects the presence of a pesticide above the action levels listed in Exhibit A, Table 3 in a sample:

(a) During an initial test where no reanalysis is requested; or

(b) Upon reanalysis as described in OAR 333-007-0450(1). [Table not included. See ED. NOTE.]

(3) The Authority will review and update, if necessary, the analytes listed in Exhibit A, Table 3, at least every two years.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0410
Standards for Testing Solvents

(1) A marijuana item required to be tested for solvents must be tested by a laboratory for the analytes listed in Exhibit A, Table 4 incorporated by reference. [Table not included. See ED. NOTE.]

(2) A batch fails solvent testing if a laboratory, during an initial test where no reanalysis is requested or upon reanalysis as described in OAR 333-007-0450(1):

(a) Detects the presence of a solvent above the action level listed in Exhibit A, Table 4 in a sample; or [Table not included. See ED. NOTE.]

(b) Calculates a RPD of more than 20 percent between the field primary result of the sample and the field duplicate result.

(3) The Authority will review and update, if necessary, the analytes listed in Exhibit A, Table 4, at least every two years. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0420
Standards for Testing Water Activity and Moisture Content

(1) Usable marijuana must be tested by a laboratory for:

(a) Water activity; and

(b) Moisture content.

(2) If a sample has a water activity rate of more than 0.65 Aw the sample fails.

(3) If a sample has a moisture content of more than 15 percent the result must be reported to the licensee but the sample does not fail.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0430
Standards for THC and CBD Testing

(1) A laboratory must test for the following when testing a marijuana item for potency:

(a) THC.

(b) THCA.

(c) CBD.

(d) CBDA.

(2) A process lot of a cannabinoid concentrate, extract or product that has not successfully completed process validation fails potency testing if, based on an initial test where no reanalysis is requested or upon reanalysis as described in OAR 333-007-0450(1):

(a) The amount of THC, as calculated pursuant to OAR 333-064-0100, between samples taken from the batch exceeds 30 percent RSD; or

(b) The amount or percentage of THC, as calculated pursuant to OAR 333-064-0100, exceeds the maximum concentration limits permitted in package as specified in OAR 333-007-0200 to 333-007-0220, as applicable.

(3) A process lot of a cannabinoid concentrate, extract or product that has successfully completed process validation fails potency testing if, based on an initial test where no reanalysis is requested or upon reanalysis as described in OAR 333-007-0450(1):

(a) The amount of THC, as calculated pursuant to OAR 333-064-0100, between the sample and the field duplicate exceeds 20 percent RPD; or

(b) The amount or percentage of THC, as calculated pursuant to OAR 333-064-0100, exceeds the maximum concentration limits permitted in a package as specified in OAR 333-007-0200 to 333-007-0220, as applicable.

(4) A sample cannot fail CBD testing.

(5) Notwithstanding section (2)(a) and (3)(a) of this rule, a sample that has less than 5 mg of THC as calculated pursuant to OAR 333-064-0100 does not fail potency testing based on exceedance of the RSD or RPD as described in section (2)(a) or (3)(a) of this rule.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0440
Process Validation

(1) A laboratory may perform process validation tests on three consecutive process lots of cannabinoid concentrates, extracts or products for a processor or processing site if the processor or processing site informs the laboratory, in writing:

(a) That sampling and testing is for the purposes of process validation; and

(b) For cannabinoid products, the expected THC range for the product.

(2) Samples taken for purposes of process validation testing may not be combined.

(3) Samples of cannabinoid concentrate and extracts must be tested for:

(a) Pesticides in accordance with OAR 333-007-0400,

(b) Solvents in accordance with OAR 333-007-0410.

(4) Samples of cannabinoid products must be tested for THC concentration in accordance with OAR 333-007-0430, as calculated pursuant to OAR 333-064-0100.

(5) During process validation a batch passes:

(a) Pesticide testing if each sample is below the action limit established in OAR 333-007-0400.

(b) Solvent testing if:

(A) Each sample is below the action limit established in OAR 333-007-0410; and

(B) The results above the LOQ are not greater than 30 percent RSD between samples.

(c) THC concentration testing if:

(A) The amount of THC, as calculated pursuant to OAR 333-064-0100, between samples taken from the batch does not exceed 30 percent RSD; and

(B) The amount or percentage of THC as calculated pursuant to OAR 333-064-0100, does not exceed the maximum concentration limit permitted in a package as specified in OAR 333-007-0200 to 333-007-0220, as applicable.

(6) A laboratory must identify on a form prescribed by the Authority if a batch undergoing process validation has passed for any of the following:

(a) Pesticides, if applicable.

(b) Solvents, if applicable.

(c) THC concentration as calculated pursuant to OAR 333-064-0100, if applicable.

(7) A process lot sampled and tested for purposes of process validation may be sold or transferred if the samples pass all the required tests.

(8) A processor or processing site must undergo process validation for a product again or must have batches sampled and tested as if the product had not undergone process validation if:

(a) There are any changes to the standard operating procedures for that product.

(b) There are any changes in the type of ingredient in the product, except for a difference in the strain of usable marijuana, or the purity of an ingredient.

(9) Process validation is only valid for two years.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0450
Failed Test Samples

(1) If a sample fails any initial test the laboratory that did the testing may reanalyze the sample. If the sample passes, another laboratory must resample the batch and confirm that result in order for the batch to pass testing.

(2) If a sample fails a test or a reanalysis under section (1) of this rule the batch:

(a) May be remediated or sterilized in accordance with this rule; or

(b) If it is not or cannot be remediated or sterilized under this rule, must be destroyed in a manner specified by the Authority or the Commission.

(3) If a licensee or registrant is permitted under this rule to sell or transfer a batch that has failed a test, the licensee or registrant must notify the licensee or registrant to whom the batch is sold or transferred of the failed test.

(4) Failed microbiological contaminant testing.

(a) If a sample from a batch of usable marijuana fails microbiological contaminant testing the batch may be used to make a cannabinoid concentrate or extract if the processing method effectively sterilizes the batch, such as a method using a hydrocarbon based solvent or a CO2 closed loop system.

(b) If a sample from a batch of a cannabinoid concentrate or extract fails microbiological contaminant testing the batch may be further processed if the processing method effectively sterilizes the batch, such as a method using a hydrocarbon based solvent or a CO2 closed loop system.

(c) A batch that is sterilized in accordance with subsection (a) or (b) of this section must be sampled and tested in accordance with these rules and must be tested if not otherwise required for that product, for microbiological contaminants, solvents and pesticides.

(d) A batch that fails microbiological contaminant testing after undergoing a sterilization process in accordance with subsection (a) or (b) of this section must be destroyed in a manner specified by the Authority or the Commission.

(5) Failed solvent testing.

(a) If a sample from a batch fails solvent testing the batch may be remediated using procedures that would reduce the concentration of solvents to less than the action level.

(b) A batch that is remediated in accordance with subsection (a) of this section must be sampled and tested in accordance with these rules and must be tested if not otherwise required for that product under these rules, for solvents and pesticides.

(c) A batch that fails solvent testing that is not remediated or that if remediated fails testing must be destroyed in a manner specified by the Authority or the Commission.

(6) Failed water activity testing.

(a) If a sample from a batch of usable marijuana fails for water activity the batch from which the sample was taken may:

(A) Be used to make a cannabinoid concentrate or extract; or

(B) Continue to dry or cure.

(b) A batch that undergoes additional drying or curing as described in paragraph (a)(B) of this section must be sampled and tested in accordance with these rules.

(7) Failed pesticide testing.

(a) If a sample from a batch fails pesticide testing the batch may not be remediated and must be destroyed in a manner approved by the Authority or the Commission.

(b) The Authority must report to the Oregon Department of Agriculture all test results that show that a sample failed a pesticide test.

(8) Failed potency testing.

(a) A marijuana item that fails potency testing under OAR 333-007-0430(2)(a) or (3)(a) may be repackaged in a manner that enables the item to meet the standard in OAR 333-007-0430(2)(a) or (3)(a).

(b) A marijuana item that is repackaged in accordance with this section must be sampled and tested in accordance with these rules.

(9) If a sample fails a test after undergoing remediation or sterilization as permitted under this rule the batch must be destroyed in a manner approved by the Authority or the Commission.

(10) An Authority representative must witness the destruction of a batch if destruction is required by this rule.

(11) A registrant must inform a laboratory prior to samples being taken that the batch has failed a test and is being retested after undergoing remediation or sterilization.

(12) A registrant must, as applicable:

(a) Have detailed procedures for sterilization processes to remove microbiological contaminants and for reducing the concentration of solvents.

(b) Document all sampling, testing, sterilization, remediation and destruction that are a result of failing a test under these rules.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0470
Tentative Identification of Compounds

(1) Tentatively Identified Compounds (TICs) are compounds detected in a sample using gas chromatography mass spectrometry that are not among the target analytes for the residual solvent analysis.

(2) The Authority may initiate an investigation of a registrant upon receipt of a TICS report from a laboratory and may require a registrant to submit samples for additional testing, including testing for analytes that are not required by these rules, at the registrant's expense.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0480
Audit and Random Testing

(1) The Authority may require a registrant to submit samples identified by the Authority to a laboratory of the registrant's choosing to be tested in order to determine whether a registrant is in compliance with OAR 333-007-0300 through 333-007-0490, and may require additional testing that is not required by these rules.

(2) A laboratory doing audit testing must comply with these rules, to the extent they are applicable, and if conducting testing not required by these rules, may only use Authority approved methods.

(3) The Authority must establish a process for the random testing of marijuana items for microbiological contaminants that ensures each registrant tests every product for microbiological contaminants at least once a year.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-007-0490
Waiver of Sampling and Testing Requirements

(1) Solvent testing.

(a) The Commission or the Authority may, upon receipt of a written request from a licensee or registrant, waive a requirement that every batch of a process lot be tested for solvents, if the licensee or registrant can demonstrate that none of the batches from any of the previous four process lots tested failed a solvent test.

(b) In order to qualify for a waiver under this section the fourth process lot must be processed at least 30 days after the first.

(c) If the waiver is granted the Commission or Authority must provide notice, in writing, to the registrant or licensee of the waiver and how long the waiver will be in effect.

(d) If the Commission or the Authority waives the testing requirement the licensee or registrant is subject to random testing and the Commission or the Authority shall notify the licensee or registrant when a process lot must be tested in accordance with these rules.

(2) Sampling.

(a) The Commission or the Authority may, upon receipt of a written request from a processor or processing site waive the sampling requirements in OAR 333-007-0360(2)(a) for a particular product if the processor processing site:

(A) Can demonstrate that none of the batches from any of the previous four process lots tested failed any test;

(B) Submits to the Commission or the Authority detailed processing standard operating procedures that demonstrate the product is uniform and uniform from process lot to process lot;

(C) Can demonstrate that it has and follows quality control measures; and

(D) Can demonstrate that subjecting a product to process validation under OAR 333-007-0440 is cost prohibitive.

(b) In order to qualify for a waiver under this section the fourth process lot must be processed at least 30 days after the first.

(c) If the waiver is granted the Commission or Authority must provide notice, in writing, to the registrant or licensee of the waiver, how long the waiver will be in effect, and the sampling that is required of the product for which the waiver was approved.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0010
Definitions

For the purposes of OAR chapter 333, division 8 the following definitions apply unless otherwise indicated:

(1) "Advertising" means publicizing the trade name of a PRMG, registered processing site or dispensary together with words or symbols referring to marijuana or publicizing the brand name of marijuana or a medical cannabinoid product, concentrate or extract in any medium.

(2) "Applicant" means, as applicable to the registration being applied for:

(a) An individual applying for a registry identification card under ORS 475B.415.

(b) An individual applying for a grow site registration under ORS 475B.420.

(c) A person applying for a marijuana processing site registration under ORS 475B.435.

(d) A person applying for a medical marijuana dispensary registration under ORS 475B.450.

(3) "Attending physician" means a Doctor of Medicine (MD) or Doctor of Osteopathy (DO), licensed under ORS chapter 677, who has primary responsibility for the care and treatment of a person diagnosed with a debilitating medical condition.

(4) "Attending physician statement" or "APS" means the form, prescribed by the Authority and signed by an attending physician, that states the individual has been diagnosed with a debilitating medical condition and that the medical use of marijuana may mitigate the symptoms or effects of the individual's debilitating medical condition.

(5) "Authority" means the Oregon Health Authority.

(6) "Business day" means Monday through Friday excluding legal holidays.

(7) "CBD" means cannabidiol.

(8) "Cannabinoid" means any of the chemical compounds that are the active constituents of marijuana.

(9) "Cannabinoid concentrate" means a substance obtained by separating cannabinoids from marijuana by:

(a) A mechanical extraction process;

(b) A chemical extraction process using a nonhydrocarbon-based solvent, such as vegetable glycerin, vegetable oils, animal fats, isopropyl alcohol or ethanol;

(c) A chemical extraction process using the hydrocarbon-based solvent carbon dioxide, provided that the process does not involve the use of high heat or pressure; or

(d) Any other process authorized in these rules.

(10) "Cannabinoid edible" means food or potable liquid into which a cannabinoid concentrate, cannabinoid extract or dried leaves or flowers of marijuana have been incorporated.

(11) "Cannabinoid extract" means a substance obtained by separating cannabinoids from marijuana by:

(a) A chemical extraction process using a hydrocarbon-based solvent, such as butane, hexane or propane; or

(b) A chemical extraction process using the hydrocarbon-based solvent carbon dioxide, if the process uses high heat or pressure.

(12) "Cartoon" means any drawing or other depiction of an object, person, animal, creature or any similar caricature that satisfies any of the following criteria:

(a) The use of comically exaggerated features;

(b) The attribution of human characteristics to animals, plants or other objects, or the similar use of anthropomorphic technique; or

(c) The attribution of unnatural or extra-human abilities, such as imperviousness to pain or injury, X-ray vision, tunneling at very high speeds or transformation.

(13) "Commission" means the Oregon Liquor Control Commission.

(14) "Conviction" means an adjudication of guilt upon a verdict or finding entered in a criminal proceeding in a court of competent jurisdiction.

(15) "Database" means the electronic system established pursuant to ORS 475B.458, in which the Authority stores the information PRMGs, registered processing sites and dispensaries are required to submit under these rules.

(16) "Debilitating medical condition" means:

(a) Cancer, glaucoma, a degenerative or pervasive neurological condition, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, or a side effect related to the treatment of those medical conditions;

(b) A medical condition or treatment for a medical condition that produces, for a specific patient, one or more of the following:

(A) Cachexia;

(B) Severe pain;

(C) Severe nausea;

(D) Seizures, including but not limited to seizures caused by epilepsy; or

(E) Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis;

(c) Post-traumatic stress disorder; or

(d) Any other medical condition or side effect related to the treatment of a medical condition adopted by the Authority by rule or approved by the Authority pursuant to a petition filed under OAR 333-008-0090.

(17) "Delivery" has the meaning given that term in ORS 475B.410.

(18)(a) "Designated primary caregiver" means an individual who:

(A) Is 18 years of age or older;

(B) Has significant responsibility for managing the well-being of a person who has been diagnosed with a debilitating medical condition; and

(C) Is designated as the person responsible for managing the well-being of a person who has been diagnosed with a debilitating medical condition on that person's application for a registry identification card or in other written notification submitted to the Authority.

(b) "Designated primary caregiver" does not include a person's attending physician.

(19) "Direct interest" means an interest that is held in the name of the individual.

(20) "Domicile" means the place an individual intends as his or her fixed place of abode or habitation where he or she intends to remain and to which, if absent, the individual intends to return.

(21) "Elementary school" means a learning institution containing any combination of grades Kindergarten through 8.

(22) "Employee":

(a) Means any individual, including an alien, employed for remuneration or under a contract of hire, written or oral, express or implied, by an employer.

(b) Does not mean an individual who volunteers or donates services performed for no remuneration or without expectation or contemplation of remuneration as adequate consideration for the services performed for a religious or charitable institution or a governmental entity.

(23) "Food stamps" means the Supplemental Nutrition Assistance Program as defined and governed by ORS 411.806 through 411.845.

(24) "Grandfathered grow site" means a grow site registered by the Authority that has been approved by the Authority under OAR 333-008-0520 that can have up to:

(a) 24 mature marijuana plants if the location is within city limits and zoned residential; or

(b) 96 mature marijuana plants if the location is within city limits but not zoned residential or not within city limits.

(25) "Grow site" means a location registered under ORS 475B.420 where marijuana is produced for use by a patient or, with permission from a patient, for transfer to a registered processing site or dispensary.

(26) "Grow site registration card" means a card issued by the Authority that identifies the address of a marijuana grow site and the PRMG.

(27) "Immature marijuana plant" means a marijuana plant that is not flowering.

(28) "Indirect interest" means:

(a) An interest that is owned by a business entity that is owned, in whole or in part and either directly or indirectly, through one or more other intermediate business entities, by the individual; or

(b) An interest held in the name of another but the benefits of ownership of which, the individual is entitled to receive.

(29) "Individual who has a financial interest" in a business entity that owns a processing site or dispensary means:

(a) If the business entity is a corporation:

(A) Stockholders: Any individual who owns, directly or indirectly, 10 percent or more of the outstanding stock of such corporation.

(B) Directors: Any director of the corporation who receives compensation for acting in that capacity or who owns, directly or indirectly, 5 percent or more of the outstanding stock of such corporation.

(C) Officers: Any officer of the corporation who receives compensation for acting in that capacity or who owns, directly or indirectly, 5 percent or more of the outstanding stock of such corporation.

(b) If the business entity is a trust:

(A) Trustees: Any individual who is a trustee of the trust and who receives compensation for acting in that capacity and any individual who owns, directly or indirectly, 10 percent or more of the ownership interests of a business entity that is a trustee of the trust and that receives compensation for acting in that capacity.

(B) Beneficiaries: Any individual who is entitled to receive, directly or indirectly, income or benefit from the trust.

(c) If the business entity is a partnership:

(A) General Partners: Any individual who is a general partner of the partnership and who receives compensation for acting in that capacity or who owns 5 percent or more of the ownership interests of the partnership and any individual who owns, directly or indirectly, 10 percent or more of the ownership interests of a business entity that is a general partner of the partnership and that receives compensation for acting in that capacity or owns 5 percent or more of the ownership interests of the partnership.

(B) Limited Partners: Any individual who is a limited partner of the partnership and who owns 10 percent or more of the ownership interests of the partnership and any individual who owns, directly or indirectly, 10 percent or more of the ownership interests of a business entity that is a limited partner of the partnership and that owns 10 percent or more the ownership interests of the partnership.

(d) If the business entity is a joint venture: Any individual who is entitled to receive, directly or indirectly, income or benefit from the joint venture.

(e) If the business entity is a limited liability company:

(A) Managers: Any individual who is a manager of the limited liability company and who receives compensation for acting in that capacity or who owns 5 percent or more of the ownership interests of the limited liability company and any individual who owns, directly or indirectly, 10 percent or more of the ownership interests of a business entity that is a manager of the limited liability company and that receives compensation for acting in that capacity or owns 5 percent or more of the ownership interests of the limited liability company.

(B) Members: Any individual who is a member of the limited liability company and who owns 10 percent or more of the ownership interests of the limited liability company and any individual who owns, directly or indirectly, 10 percent or more of the ownership interests of a business entity that is a member of the limited liability company and that owns 10 percent or more of the ownership interests of the limited liability company.

(f) Immediate family members: Any person, 18 years of age or older, involved in a marijuana processing site or dispensary, in any capacity, who is a member of the immediate family of any individual who otherwise has a financial interest in the business entity that owns the marijuana processing site or dispensary. A person is a member of the immediate family of the individual if the person receives more than 50 percent of his or her financial support from that individual.

(g) Landlord: Any individual who is a landlord of a processing site or dispensary and who is entitled to receive 40 percent or more of the proceeds from the marijuana processing site or dispensary as a part of lease payments or rent, any individual who owns, directly or indirectly, 10 percent or more of the ownership interests of a business entity that is a landlord of a processing site or dispensary and that is entitled to receive 40 percent or more of the proceeds from the marijuana processing site or dispensary as part of lease payments or rent, and any individual who the Authority finds, based on reasonably reliable information, exerts influence over the operation of the marijuana processing site or dispensary through a landlord-tenant relationship and receives a portion of the proceeds from that marijuana processing site or dispensary.

(h) Other forms of business organization: If the form of business entity is not expressly addressed in subsections (a) to (g) of this section, the Authority will, in determining individuals who have a financial interest in the business entity, apply the portions of this definition applicable to the business entity that are most similar to the subject business entity, interpreting the terminology and concepts of this definition in the context of the subject business entity as necessary or appropriate.

(30) "Indoor production" for purposes of OAR 333-008-0580 means producing marijuana in any manner:

(a) Utilizing artificial lighting on mature marijuana plants; or

(b) Other than "outdoor production" as that is defined in this rule.

(31) "Limited access area" means:

(a) For a dispensary a building, room, or other contiguous area on a dispensary premises where a marijuana item is present but does not include the area where marijuana items are transferred to a patient or designated primary caregiver.

(b) For a processing site a building, room, or other contiguous area on a processing site premises where a marijuana item is present.

(32)(a) "Marijuana" means the plant Cannabis family Cannabaceae, any part of the plant Cannabis family Cannabaceae and the seeds of the plant Cannabis family Cannabaceae.

(b) "Marijuana" does not include industrial hemp, as defined in ORS 571.300.

(33) "Marijuana item" means marijuana, cannabinoid concentrates, cannabinoid extracts, medical cannabinoid products, and immature marijuana plants.

(34) "Marijuana processing site" or "processing site" means a marijuana processing site registered under ORS 475B.435 or a site for which an applicant has submitted an application for registration under ORS 475B.435.

(35) "Mature marijuana plant" means a marijuana plant that is not an immature marijuana plant.

(36)(a) "Medical cannabinoid product" means a cannabinoid edible and any other product intended for human consumption or use, including a product intended to be applied to a person's skin or hair, that contains cannabinoids or dried leaves or flowers of marijuana.

(b) "Medical cannabinoid product" does not include:

(A) Usable marijuana by itself;

(B) A cannabinoid concentrate by itself;

(C) A cannabinoid extract by itself; or

(D) Industrial hemp, as defined in ORS 571.300.

(37) "Medical marijuana dispensary" means a medical marijuana dispensary registered under ORS 475B.450 or a site for which an applicant has submitted an application for registration under ORS 475B.450.

(38) "Medical use of marijuana" means the production, processing, possession, delivery, or administration of marijuana, or use of paraphernalia used to administer marijuana to mitigate the symptoms or effects of a debilitating medical condition.

(39) "Minor" means an individual under the age of 18.

(40) "Oregon Health Plan (OHP)" means the medical assistance program administered by the Authority under ORS chapter 414.

(41) "OMMP" means the section within the Authority that administers the provisions of ORS 475B.400 to 475B.525, the applicable provisions of 475B.550 to 475B.590, 475B.600 to 475B.655, and the rules in OAR chapter 333, divisions 7 and 8.

(42) "Outdoor production" for purposes of OAR 333-008-0580 means producing marijuana:

(a) In an expanse of open or cleared ground open to the air; or

(b) In a greenhouse, hoop house or similar non-rigid structure that does not utilize any artificial lighting on mature marijuana plants, including but not limited to electrical lighting sources.

(43) "Parent or legal guardian" means the custodial parent or legal guardian with responsibility for health care decisions for the person under 18 years of age.

(44) "Patient" has the same meaning as "registry identification cardholder."

(45) "Person designated to produce marijuana by a registry identification cardholder" or "person designated to produce marijuana by a patient" mean a person designated to produce marijuana by a patient under ORS 475B.420 who produces marijuana for that patient at an address:

(a) Other than the address where the patient resides; or

(b) Where more than 12 mature marijuana plants are produced.

(46) "Person responsible for a marijuana grow site," or "PRMG" mean any individual designated by a patient to produce marijuana for the patient, including a patient who identifies him or herself as a person responsible for the marijuana grow site.

(47) "Personal agreement" means a document, as described in ORS 475B.425 signed and dated by a patient, assigning a patient's right to possess seeds, immature marijuana plants and usable marijuana to a PRMG.

(48) "Point of sale" means a specific location within a point of sale area at which the transfer of a marijuana item occurs.

(49) "Point of sale area" means a secure area where a registered dispensary transfers a marijuana item to a patient or caregiver.

(50) "Premises" means a location registered by the Authority as a processing site or dispensary under these rules and includes all areas at the location that are used in the business operated at the location, including offices, kitchens, rest rooms and storerooms, including all public and private areas where individuals are permitted to be present.

(51) "Primary responsibility" as that term is used in relation to an attending physician means that the physician:

(a) Provides primary health care to the patient; or

(b) Provides medical specialty care and treatment to the patient as recognized by the American Board of Medical Specialties; or

(c) Is a consultant who has been asked to examine and treat the patient by the patient's primary care physician licensed under ORS chapter 677, the patient's physician assistant licensed under ORS chapter 677, or the patient's nurse practitioner licensed under ORS chapter 678; and

(d) Has reviewed a patient's medical records at the patient's request and has conducted a thorough physical examination of the patient, has provided or planned follow-up care, and has documented these activities in the patient's medical record.

(52) "Process" means the compounding or conversion of marijuana into medical cannabinoid products, cannabinoid concentrates or cannabinoid extracts.

(53) "Production" or "growing" means:

(a) Planting, cultivating, growing, trimming or harvesting marijuana; or

(b) Drying marijuana leaves or flowers.

(54) "Registry identification card" means a document issued by the Authority under ORS 475B.415 that identifies a person authorized to engage in the medical use of marijuana, and, if the person has a designated primary caregiver under ORS 475B.418, the person's designated primary caregiver.

(55) "Registry identification cardholder" means a person to whom a registry identification card has been issued under ORS 475B.415(5)(a) and has the same meaning as patient.

(56) "Remuneration" means compensation resulting from the employer-employee relationship, including wages, salaries, incentive pay, sick pay, compensatory pay, bonuses, commissions, stand-by pay, and tips.

(57) "Replacement card" means a new card issued in the event that:

(a) A patient's registry identification card, a designated primary caregiver's or a PRMG's identification card, or grow site registration card is lost or stolen; or

(b) A patient's designation of primary caregiver, PRMG or grow site has changed.

(58) "Resident" means an individual who has primary domicile within this state.

(59) "Safe" means:

(a) A metal receptacle with a locking mechanism capable of storing all usable marijuana at a registered premises that:

(A) Is rendered immobile by being securely anchored to a permanent structure of the building; or

(B) Weighs more than 750 pounds.

(b) A vault; or

(c) A refrigerator or freezer capable of being locked for storing edibles or other finished products that require cold storage that:

(A) Is rendered immobile by being securely anchored to a permanent structure of the building; or

(B) Weighs more than 750 pounds; and

(C) If it has a glass that makes up part or all of the door or exterior walls, the glass is rated unbreakable.

(60) "Secondary school" means a learning institution containing any combination of grades 9 through 12 and includes those institutions that provide junior high schools which include 9th grade.

(61) "Secure area" means a room:

(a) With doors that are kept locked and closed at all times except when the doors are in use;

(b) Where access is only permitted as authorized in these rules; and

(c) Not visible from outside the room or within public view.

(62) "Supplemental Security Income (SSI)" means the monthly benefit assistance program administered by the federal government for persons who are age 65 or older, or blind, or disabled and who have limited income and financial resources.

(63) "These rules" means OAR 333-008-0010 to 333-008-0750.

(64) "THC" means tetrahydrocannabinol.

(65)(a) "Usable marijuana" means the dried leaves and flowers of marijuana.

(b) "Usable marijuana" does not include:

(A) The seeds, stalks and roots of marijuana; or

(B) Waste material that is a by-product of producing marijuana.

(66) "Vault" means an enclosed area that is constructed of steel-reinforced or block concrete and has a door that contains a multiple-position combination lock or the equivalent, a relocking device or equivalent, and a steel plate with a thickness of at least one-half inch.

(67) "Written documentation" means a statement signed and dated by the attending physician of a person diagnosed with a debilitating medical

condition or copies of the person's relevant medical records, maintained in accordance with standard medical record practices.

(68) "Zoned for residential use" means the only primary use allowed outright in the designated zone is residential.

Stat. Auth.: ORS 475B.525
Stats. Implemented: ORS 475B.400 – 475B.525
Hist.: OHD 15-1998(Temp), f. & cert. ef. 12-24-98 thru 6-22-99; OHD 3-1999, f. & cert. ef. 4-29-99; OHD 13-2000(Temp), f. & cert. ef. 12-21-00 thru 6-15-01; OHD 18-2001, f. & cert. ef. 8-9-01; OHD 19-2001(Temp), f. & cert. ef. 8-10-01 thru 1-31-02; Administrative correction 3-14-02; OHD 6-2002, f. & cert. ef. 3-25-02; PH 9-2003, f. 6-26-03, cert. ef. 7-1-03; PH 18-2005, f. 12-30-05, cert. ef. 1-1-06; PH 15-2007, f. 12-19-07, cert. ef. 1-1-08; PH 21-2010, f. & cert. ef. 9-13-10; PH 5-2011(Temp), f. & cert. ef. 7-1-11 thru 12-27-11; PH 8-2011, f. 9-30-11, cert. ef. 10-1-11; PH 1-2014, f. & cert. ef. 1-13-14; PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 16-2015(Temp), f. & cert. ef. 9-22-15 thru 3-19-16; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0020
New Registry Identification Card Application Process

(1) To apply for a registry identification card an individual must submit the following:

(a) An application form, prescribed by the Authority, signed and dated by the applicant.

(b) A legible copy of the individual's valid government issued photographic identification that includes the applicant's last name, first name, and date of birth.

(c) An APS or written documentation that may consist of relevant portions of the applicant's medical record, signed by the applicant's attending physician within 90 days of the date of receipt by the Authority, which describes the applicant's debilitating medical condition and states that the use of marijuana may mitigate the symptoms or effects of the applicant's debilitating medical condition.

(d) Proof of residency in accordance with OAR 333-008-0022.

(e) If applicable, a completed and notarized "Declaration of Person Responsible for Minor" form for a person under 18 years of age, signed and dated by the minor's parent or legal guardian.

(f) An application fee as specified in OAR 333-008-0021.

(g) If applicable, documentation required in OAR 333-008-0021 to qualify for a reduced fee.

(2) If the applicant is designating a primary caregiver, the applicant must complete the caregiver portion of the application and submit a legible copy of the designated primary caregiver's valid government issued photographic identification that includes the caregiver's last name, first name, and date of birth. The applicant may also designate an organization that provides hospice, palliative or home health care services, or a residential facility as defined in ORS 443.400, under ORS 475B.419, as an additional caregiver.

(3) If an applicant intends to produce marijuana for him or herself or designate another person to produce marijuana for him or her, the applicant or the individual designated to be the PRMG must complete the grow site registration portion of the application and submit:

(a) A legible copy of the designated PRMG's valid government issued photographic identification that includes the last name, first name, and date of birth.

(b) The grow site address.

(c) If the grow site is within city limits, documentation that shows the zoning designation for the grow site address.

(d) Except for a patient producing marijuana for him or herself at his or her residence, the grow site registration fee as specified in OAR 333-008-0021(4), unless the Authority has established an online payment system for grow site registration in which case the fee must be paid online in accordance with instructions from the Authority.

(4) If the Authority establishes an online payment system for payment of a grow site registration fee the Authority must notify the person designated on the application as the PRMG with instructions for how to pay the fee online and the deadline by which the fee must be paid.

(5) Applications must be mailed to the address listed in section (6) of this rule or hand-delivered to the OMMP dropbox at 800 N.E. Oregon St., Portland, Oregon 97232, unless the Authority has established an electronic application process at which time applications and accompanying documentation must be submitted electronically.

(6) The application forms referenced in this rule may be downloaded at www.healthoregon.org/ommp or obtained by contacting OMMP at PO Box 14450, Portland, OR 97293-0450 or by calling 971-673-1234.

(7) Acceptable forms of current government issued photographic identification include but are not limited to:

(a) Driver's license;

(b) State identification card;

(c) Passport; or

(d) Military identification card.

Stat. Auth.: ORS 475B.415, 475B.419, 475B.525
Stats. Implemented: ORS 475B.415
Hist.: OHD 3-1999, f. & cert. ef. 4-29-99; OHD 13-2000(Temp), f. & cert. ef. 12-21-00 thru 6-15-01; OHD 18-2001, f. & cert. ef. 8-9-01; OHD 19-2001(Temp), f. & cert. ef. 8-10-01 thru 1-31-02; Administrative correction 3-14-02; OHD 6-2002, f. & cert. ef. 3-25-02; PH 9-2003, f. 6-26-03, cert. ef. 7-1-03; PH 38-2004, f. 12-22-04, cert. ef. 1-1-05; PH 17-2005, f. 11-25-05, cert. ef. 12-1-05; PH 18-2005, f. 12-30-05, cert. ef. 1-1-06; PH 15-2007, f. 12-19-07, cert. ef. 1-1-08; PH 14-2010(Temp), f. & cert. ef. 7-6-10 thru 12-31-10; PH 27-2010, f. & cert. ef. 12-28-10; PH 8-2011, f. 9-30-11, cert. ef. 10-1-11; PH 9-2013(Temp), f. & cert. ef. 10-2-13 thru 3-30-14; PH 1-2014, f. & cert. ef. 1-13-14; PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 16-2014, f. & cert. ef. 6-5-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0021
Patient and PRMG New and Renewal Fees

(1) All fees referenced in this rule are non-refundable.

(2) New and Renewal Application Fee. A patient must pay a $200 application fee unless the applicant qualifies for a reduced fee under section (3) of this rule.

(3) Reduced Fees.

(a) An applicant receiving SSI benefits: $20. In order to qualify for the reduced fee the applicant must submit at the time of application a copy of a current monthly SSI benefit statement showing dates of coverage.

(b) An applicant enrolled in OHP: $50. In order to qualify for the reduced fee the applicant must submit a copy of the applicant's current eligibility statement or card.

(c) An applicant receiving food stamp benefits through the Oregon SNAP: $60. In order to qualify for the reduced fee the applicant must submit at the time of application current proof of his or her food stamp benefits.

(d) An applicant who has served in the Armed Forces of the United States: $20. In order to qualify for the reduced fee the applicant must provide proof of having served in the Armed Forces, such as but not limited to, submitting a Veteran's Administration form DD-214.

(4) Grow Site Registration Fee: $200.

(5) Replacement Card Fees. If a patient, designated primary caregiver or PRMG needs to obtain a replacement card the fee is $100. If the patient qualifies for a reduced application fee of $20, the fee to receive any of the replacement cards is $20.

(6) All fees must be paid at the time a new or renewal application is submitted, or when an application to add or change a PRMG is submitted under OAR 333-008-0047 and may be paid in the form of bank check, money order, or personal check, unless the Authority has established an online payment system in which case payments must be made online. The Authority does not accept responsibility for payments that are lost in the mail or stolen in transit.

(7) The Authority shall notify an applicant who submits a reduced application fee if the applicant is not eligible for the reduced fee and will allow the applicant 14 calendar days from the date of notice to pay the correct application fee or submit current valid proof of eligibility for a reduced fee.

Stat. Auth.: ORS 475B.415, 475B.420, 475B.525
Stats. Implemented: ORS 475B.415
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0022
Proof of Residency

(1) If an applicant for a registry identification card does not have a valid Oregon driver license or Oregon identification card, the applicant must submit documentation that shows the applicant is a resident of Oregon, such as but not limited to a current lease agreement or current utility bill that has the applicant's name and address.

(2) Residency must be maintained by patients while registered with the Authority.

Stat. Auth.: ORS 475B.415, 475B.420, 475B.525
Stats. Implemented: ORS 475B.415
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0023
Patient Application Review Process

(1) The Authority must review a patient application to determine if it is complete.

(a) If an applicant does not provide all the information required in OAR 333-008-0020 or pay the applicable fee the Authority must notify the applicant of the information that is missing or the fee that was not paid, and allow the applicant 14 calendar days to submit the missing information.

(b) If an applicant does not provide the information requested in subsection (1)(a) of this rule the application must be denied in accordance with OAR 333-008-0035.

(2) The Authority may verify the information on each application, verify any accompanying documentation submitted with an application, or request additional information from the applicant or other individuals named on the application.

(3) If the Authority is unable to verify that the applicant's attending physician meets the definition under OAR 333-008-0010 the applicant will be allowed 30 days to submit a new APS or written documentation from a physician meeting the requirements of these rules. Failure to submit the required attending physician documentation is grounds for denial under ORS 475B.415(8) and OAR 333-008-0035.

(4) If an applicant fails to submit information necessary for the Authority to verify information on the application, fails to submit information necessary to verify any accompanying documentation submitted with an application, or fails to cooperate with the Authority in obtaining information, such as but not limited to refusing to sign an authorization for disclosure of medical records within timeframes established by the Authority, the Authority will reject the application as incomplete.

(5) An applicant whose application is rejected as incomplete may reapply at any time. If the individual reapplies within a year the application fee may be applied toward a new application.

(6) Upon receipt of a complete application, including payment of the required application fee, the Authority must issue a receipt to the applicant verifying that a complete application has been received. A receipt issued under this section has the same legal effect as a registry identification card for 30 days following the date on which the receipt was issued to the applicant.

(7) The Authority shall approve or deny an application within 30 days after receiving a complete application.

Stat. Auth.: ORS 475B.415, 475B.525
Stats. Implemented: ORS 475B.415
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0025
Person Responsible for a Marijuana Grow Site Criteria; Grow Site Registration Application Review Process

(1) In order to be a PRMG an individual must:

(a) Be 21 years of age or older.

(b) Not have been convicted of a Class A or Class B felony under ORS 475.752 to 475.920 for the manufacture or delivery of a controlled substance in Schedule I or Schedule II:

(A) Within the previous two years; or

(B) More than once.

(2) In addition to the application review required in OAR 333-008-0023 the Authority must:

(a) Conduct a criminal background check on any PRMG.

(b) Verify the PRMG's age.

(c) Verify the zoning of the grow site address if the grow site is within city limits.

(d) Determine the number of plants that are permitted at the grow site address.

(3) Unless the Authority has received a request for a grandfathered grow site address under OAR 333-008-0500, the grow site plant limits, on and after March 1, 2016, are as follows:

(a) A maximum of 12 mature marijuana plants if the grow site location is within city limits and zoned residential; or

(b) A maximum of 48 mature marijuana plants if the grow site location is within city limits but not zoned residential or outside city limits.

(4) The Authority must notify a patient if a PRMG or a grow site address is ineligible for registration and the patient will be allowed 14 calendar days to identify another PRMG or grow site address in accordance with OAR 333-008-0047.

Stat. Auth.: ORS 475B.420, 475B.525
Stats. Implemented: ORS 475B.420
Hist.: PH 18-2005, f. 12-30-05, cert. ef. 1-1-06; PH 15-2007, f. 12-19-07, cert. ef. 1-1-08; PH 8-2011, f. 9-30-11, cert. ef. 10-1-11; PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 16-2015(Temp), f. & cert. ef. 9-22-15 thru 3-19-16; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0033
Approval of New or Renewal PRMG and Grow Site Application; Change of PRMG

(1) The Authority must register a PRMG and a grow site address listed on an application if:

(a) The PRMG:

(A) Meets the age requirements;

(B) Passes the criminal background check;

(C) Has not violated a provision of ORS 475B.400 to 475B.525, ORS 475B.580, ORS 475B.650, OAR chapter 333, division 7, these rules, or an ordinance adopted pursuant to ORS 475B.500; and

(D) Pays the applicable fee.

(b) The grow site address does not exceed the plant limits in ORS 475B.428(3) or (4).

(2) If the Authority registers a marijuana grow site it will issue an identification card and a grow site registration card that contains at least the following information:

(a) The PRMG's name, address, date of birth, and identification card number.

(b) The effective date, date of issuance, and expiration date of the identification card.

(c) The grow site address.

(d) The patient's registry identification card number.

(3) A PRMG, except for a patient growing only for him or herself at his or her residence who is not transferring usable marijuana, seeds or immature plants to a registered processing site or dispensary, must create an online account with the Authority through which the individual must at a minimum submit the information required in OAR 333-008-0630.

(4) The Authority must notify a PRMG at the time the grow site is registered the current number of mature marijuana plants permitted at the grow site address.

(5) The Authority shall also notify a patient if the PRMG and grow site address has been approved.

(6) The Authority may only register one grow site per patient, and may only register grow sites in Oregon.

Stat. Auth.: ORS 475B.420, 475B.525
Stats. Implemented: ORS 475B.420
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0037
Denial of Designation of Caregiver or Person Responsible for a Marijuana Grow Site; Denial of Grow Site Registration

(1) The Authority may deny a designation of a primary caregiver made under ORS 475B.418 if the Authority determines that the designee or the patient violated a provision of ORS 475B.400 to 475B.525, ORS 475B.580, 475B.650, OAR chapter 333, division 7, these rules, or an ordinance adopted pursuant to ORS 475B.500.

(2) A person whose designation has been denied may not be designated as a primary caregiver under ORS 475B.418 for six months from the date of the denial unless otherwise authorized by the Authority.

(3) The Authority may deny a designation of a PRMG if the Authority determines that the applicant or the PRMG violated a provision of ORS 475B.400 to 475B.525, 475B.580, 475B.650, OAR chapter 333, division 7, these rules, or an ordinance adopted pursuant to ORS 475B.500.

(4) The Authority may deny the registration of a PRMG and grow site address if the grow site registration fee has not been paid.

Stat. Auth.: ORS 475B.415, 475B.420 & 475B.525
Stats. Implemented: ORS 475B.415, 475B.420
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0040
Annual Renewal

(1) A patient shall register on an annual basis to maintain active registration status by submitting:

(a) A renewal application prescribed by the Authority;

(b) An APS signed by the patient's attending physician within 90 days prior to the expiration date of the patient's current card, reconfirming the patient's debilitating medical condition and that the medical use of marijuana mitigates the symptoms of the patient's debilitating medical condition; and

(c) The additional information and fees required in OAR 333-008-0020.

(2) A renewal application may be submitted by mail at PO Box 14450, Portland, OR 97293-0450 or in person at the OMMP drop box located at 800 N.E. Oregon St., Portland, OR 97232.

(3) Between 60 to 90 calendar days prior to expiration, the Authority shall notify the patient of the upcoming expiration date.

(4) If a renewal application and accompanying information is not received by the expiration date on the patient's card, the patient's card and all other associated OMMP identification cards, if any, are expired. The expiration date may be extended, due to personal hardship, at the discretion of the Authority.

(5) Upon receipt of a complete renewal application, including payment of the required application fee, the Authority must issue a receipt to

the applicant verifying that a complete renewal application has been received. A receipt issued under this section has the same legal effect as a registry identification card for 30 days following the date on which the receipt was issued to the applicant.

(6) The Authority shall review and verify the renewal application information in the same manner as specified in OAR 333-008-0023 and 333-008-0025 and shall approve or deny the application in accordance with OAR 333-008-0030 to 333-008-0037, as applicable.

Stat. Auth.: ORS 475B.415, 475B.418, 475B.420, 475B.525
Stats. Implemented: ORS 475B.415, 475B.418, 475B.420
Hist.: OHD 3-1999, f. & cert. ef. 4-29-99; PH 9-2003, f. 6-26-03, cert. ef. 7-1-03; PH 18-2005, f. 12-30-05, cert. ef. 1-1-06; PH 15-2007, f. 12-19-07, cert. ef. 1-1-08; PH 21-2010, f. & cert. ef. 9-13-10; PH 27-2010, f. & cert. ef. 12-28-10; PH 8-2011, f. 9-30-11, cert. ef. 10-1-11; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0045
Notification of Changes

(1) Patient notification responsibilities.

(a) A patient must notify the Authority within 10 calendar days of any change in the patient's name, mailing address, electronic mail address, telephone number, attending physician, designated primary caregiver, PRMG, grow site address or residency, on a form prescribed by the Authority.

(b) If the patient is designating a caregiver for the first time or designating a different caregiver, the patient must include all the information and documentation specified in the form and required under OAR 333-008-0020.

(c) If a patient is adding or changing a PRMG or grow site address the patient must comply with OAR 333-008-0047.

(2) Caregiver notification responsibilities. A designated primary caregiver must notify the Authority within 10 calendar days of any change in the caregiver name, mailing address, electronic mail address, or telephone number.

(3) Person responsible for a marijuana grow site notification responsibilities. A PRMG must notify the Authority within 10 calendar days of:

(a) Any change in the person's name, mailing address, electronic mail address, or telephone number.

(b) A conviction of a Class A or Class B felony under ORS 475.752 to 475.920 for the manufacture or delivery of a controlled substance in Schedule I or Schedule II.

(4) If the Authority is notified by the patient that the patient has terminated the designation of a primary caregiver or a PRMG the Authority must notify the individuals confirming the termination, informing the individual that his or her card is no longer valid, and requesting that the card be returned to the Authority within seven calendar days. In addition the Authority must notify the PRMG whether the termination affects the person's ability to produce marijuana for other patients at the grow site address, in accordance with ORS 475B.428(6).

(5) Change in Medical Condition.

(a) If an attending physician notifies the Authority that a patient no longer has a debilitating medical condition or that that the medical use of marijuana is contraindicated for the patient's debilitating medical condition, the Authority must notify the patient that the patient's registry identification card will be invalid 30 days from the date of the notification unless the patient submits within 30 calendar days an APS or written documentation that may consist of relevant portions of the individual's medical record, signed by the individual's attending physician within the previous 90 days, which states the individual has been diagnosed with a debilitating medical condition and that the use of marijuana may mitigate the symptoms or effects of the individual's debilitating medical condition.

(b) If, due to circumstances beyond the patient's control he or she is unable to submit the documentation in subsection (a) of this section, the Authority may, upon receiving a written request from the patient, grant the patient additional time to obtain a second opinion. The Authority must notify the patient how much additional time the patient has to submit the documentation.

(6) If a patient does not intend to submit the information or does not submit the information required in section (5) of this rule within the timeframes established by the Authority, the Authority must notify:

(a) The patient that the patient's card must be returned within seven calendar days; and

(b) If applicable, the patient's designated primary caregiver and PRMG that those identification cards must be returned within seven calendar days.

(7) The Authority will review and deny a caregiver designation or register a caregiver in accordance with OAR 333-008-0023 to 333-008-0037, as applicable.

(8) Change forms may only be submitted to the Authority via mail at PO Box 14450, Portland, OR 97293-0450 or in person at the OMMP drop box located at 800 N.E. Oregon St., Portland, OR 97232 and must be accompanied by any applicable fee as specified in OAR 333-008-0021.

Stat. Auth.: ORS 475.309 & 475.312
Stats. Implemented: ORS 475.309 & 475.312
Hist.: PH 27-2010, f. & cert. ef. 12-28-10; PH 8-2011, f. 9-30-11, cert. ef. 10-1-11; PH 1-2014, f. & cert. ef. 1-13-14; PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0080
Permissible Amounts of Medical Marijuana for Patients and Caregivers

(1) A patient or the patient's designated primary caregiver may jointly possess up to six mature marijuana plants and 24 ounces of usable marijuana.

(2) A patient or the patient's designated primary caregiver may only possess cannabinoid products, concentrates or extracts in the amounts described in ORS 475B.245.

(3) A patient and designated primary caregiver must have, in his or her possession, his or her registry identification card or OMMP identification card when transporting marijuana.

(4) A patient must have, in his or her possession, his or her registry identification card when using marijuana in a location other than the residence of the cardholder.

Stat. Auth.: ORS 475B.430
Stats. Implemented: ORS 475B.430
Hist.: OHD 3-1999, f. & cert. ef. 4-29-99; OHD 18-2001, f. & cert. ef. 8-9-01; PH 18-2005, f. 12-30-05, cert. ef. 1-1-06; PH 15-2007, f. 12-19-07, cert. ef. 1-1-08; PH 21-2010, f. & cert. ef. 9-13-10; PH 8-2011, f. 9-30-11, cert. ef. 10-1-11.; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0500
Request for Grandfathered Grow Site

(1) An individual or group of individuals may submit a petition, on a form prescribed by the Authority, requesting that a grow site address be approved as a grandfathered grow site.

(2) A petition submitted under section (1) of this rule must include:

(a) For all individuals currently growing at the grow site address:

(A) Names and contact information.

(B) Copies of legible and valid government issued photographic identification that includes last name, first name, and date of birth.

(C) Copies of all current grow site registration cards issued to the PRMG for the grow site address.

(D) An attestation that the PRMG was registered at the grow site address on December 31, 2014, and has continuously been registered at the grow site address since that date.

(b) The physical address of the grow site where marijuana is being produced or intending to be produced.

(c) Documentation from a local government that indicates whether the address is within city limits and if so, the zoning designation for the address.

(d) The names and registry identification card numbers for all patients for whom each PRMG is producing at the grow site address.

(e) How many patients each PRMG was growing for on December 31, 2014.

(3) A petition that does not contain all the required information or is not accompanied by all of the documentation required to be submitted in section (2) of this rule is incomplete and will be returned to the applicant.

(4) A petition that does not include all the PRMGs currently growing at the grow site address may be considered by the Authority to be incomplete and may be returned to the applicant.

(5) Acceptable forms of current government issued photographic identification include but are not limited to:

(a) Driver's license;

(b) State identification card;

(c) Passport; or

(d) Military identification card.

Stat. Auth.: ORS 475B.525
Stats. Implemented: ORS 475B.428
Hist.: PH 33-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 2-29-16; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0510
Review of Petition For Grandfathered Grow Site

(1) Once the Authority has determined that a petition is complete it must:

(a) Conduct a criminal background check on all PRMGs listed on the application;

(b) Verify that:

(A) Each person listed on the application is 21 years of age or older;

(B) Each person has a current valid registration card and is currently registered at the grow site address;

(C) All the patients listed on the application have valid cards; and

(D) All persons were registered with the Authority on December 31, 2014, at the grow site address listed on the application and have been continuously registered at the grow site since the petition was submitted; and

(c) Verify the number of patients each PRMG was producing marijuana for, at that address on December 31, 2014.

(2) If a PRMG listed on a petition does not meet the age requirements or is disqualified to be a PRMG based on criminal convictions, the Authority must notify:

(a) The PRMG that his or her designation is revoked; and

(b) The patient that the patient's PRMG is ineligible and that the patient may submit a change form, in accordance with OAR 333-008-0047 designating a new PRMG and grow site address.

Stat. Auth.: ORS 475B.525
Stats. Implemented: ORS 475B.428
Hist.; PH 33-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 2-29-16; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0540
Requirements for Grandfathered Grow Sites; Termination of PRMG Designation; Suspension or Revocation of PRMG Registration

(1) A grandfathered grow site may only have the number of plants authorized by the Authority, based on the number of patients designating the address as a grow site on December 31, 2014. A PRMG producing marijuana at a grandfathered grow site may replace an existing patient with a new patient unless the person's designation has been terminated under ORS 475B.428(6).

(2) If the Authority suspends or revokes the registration of a PRMG that is producing marijuana at a grandfathered grow site the PRMG may not continue to grow at that address or any other grow site address that has more than:

(a) 12 mature marijuana plants if the location is within city limits and zoned residential; or

(b) 48 mature marijuana plants if the location is within city limits but not zoned residential or not within city limits.

(3) If a patient terminates the designation of a PRMG that person may not be designated to produce marijuana by another patient at the grandfathered grow site address and may not produce marijuana at any other grow site address that is authorized to have more than 48 mature marijuana plants.

(4) Approval of a grandfathered grow site is terminated once the number of mature marijuana plants, based on number of PRMGs who have been authorized to produce medical marijuana at the grow site address and the number of patients each person is producing for is less than:

(a) 12 mature marijuana plants if the location is within city limits and zoned residential; or

(b) 48 mature marijuana plants if the location is within city limits but not zoned residential or not within city limits.

Stat. Auth.: ORS 475B.525
Stats. Implemented: ORS 475B.428
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0550
General Person Responsible for a Marijuana Grow Site Requirements

(2) A PRMG must display a marijuana grow site registration card at the marijuana grow site at all times for each patient for whom marijuana is being produced.

(3) All seeds, immature marijuana plants, mature marijuana plants and usable marijuana associated with the production of marijuana for a patient by a PRMG are the property of the patient and must be provided to the patient upon request, unless the patient has assigned a portion of the right to possess the seeds, immature plants and usable marijuana to the PRMG in accordance with ORS 475B.425.

(4) All marijuana produced for a patient must be provided to the patient or designated primary caregiver when the PRMG ceases producing marijuana for the patient, unless the patient has assigned a portion of the right to possess the seeds, immature plants and usable marijuana to the PRMG in accordance with ORS 475B.425.

(5) All usable marijuana associated with the production of marijuana for a patient must be transferred to a marijuana processing site upon the patient's request.

(6) All seeds, immature marijuana plants and usable marijuana associated with the production of marijuana for a patient must be transferred to a medical marijuana dispensary upon the patient's request.

(7) If a patient terminates the designation of a PRMG that PRMG may not be designated to produce marijuana by another patient unless the grow site address is authorized to have no more than 48 mature marijuana plants.

(8) A PRMG must return the grow site registration card to the Authority when the person's designation has been terminated by a patient or the person ceases producing marijuana for him or herself or another patient.

(9) A PRMG registered with the Authority, except for a patient growing only for him or herself at his or her own residence and not transferring usable marijuana, seeds or immature plants to a registered processing site or dispensary, must create an online account with the Authority through which the individual must at a minimum submit the information required in OAR 333-008-0630.

(10) A PRMG must comply with the advertising restrictions in OAR 333-008-2070 and must remove any sign, display or advertisement if the Authority determines the PRMG has violated OAR 333-008-2070.

Stat. Auth.: ORS 475B.420 - 475B.428, 475B.525
Stats. Implemented: ORS 475B.420 - 475B.428
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0560
Grow Site Plant Limits

(1) A PRMG may not produce more than six mature marijuana plants per patient.

(2) Unless a petition has been granted under OAR 333-008-0520 or except as authorized under Oregon Laws 2016, chapter 83, section 2, a grow site address may not have more than:

(a) 12 mature marijuana plants if the location is within city limits and zoned residential; or

(b) 48 mature marijuana plants if the location is within city limits but not zoned residential or not within city limits.

(3) For purposes of determining plant limits the Authority presumes that a PRMG grows six mature plants for each patient.

Stat. Auth.: ORS 475B.428, 475B.525
Stats. Implemented: ORS 475B.428
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0570
Designation of Plants at Grow Site Address

(1) A PRMG producing marijuana at a grow site where multiple PRMGs are registered must physically identify the marijuana plants at a grow site address that are being grown by that PRMG by either:

(a) Tagging each marijuana plant with the PRMG's name, identification card number and patient identification number; or

(b) Fencing or cordoning off the PRMG's marijuana plants and posting all grow site registration cards at the location where the plants are located.

(2) If during an investigation the Authority determines that marijuana plants have not been designated by a PRMG in accordance with section (1) of this rule or there are marijuana plants at the grow site designated by an individual who is not authorized to produce marijuana at that grow site the Authority may suspend or revoke the registration of the grow site address for all PRMGs at that grow site and all the PRMG's identification cards.

(3) If during an investigation the Authority determines that a PRMG is producing marijuana plants in excess of the number of plants allowed in ORS 475B.428 the Authority may suspend or revoke the registration of the PRMG for each patient who has designated the PRMG.

Stat. Auth.: ORS 475B.428, 475B.525
Stats. Implemented: ORS 475B.428
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-0630
PRMG Documentation Requirements

(1) The reporting requirements in this rule do not apply to a patient growing only for him or herself at his or her residence, unless the patient is transferring usable marijuana to a registered processing site or dispensary.

(2) Beginning in June 2016, and on a monthly basis thereafter, no later than the 10th day of each month, a PRMG, who is not a person designated to produce marijuana by a patient, as that is defined in OAR 333-008-0010, must submit the following information to the Authority:

(a) The number of immature and mature marijuana plants and amount of usable marijuana transferred to each patient for whom the PRMG is producing marijuana;

(b) The amount of usable marijuana transferred to each registered marijuana processing site through an agreement with the patient; and

(c) The number of seeds or immature plants and the amount of usable marijuana transferred to each registered dispensary through an agreement with the patient.

(3) Beginning in June 2016, and on a monthly basis thereafter, no later than the 10th day of each month, a person designated to produce marijuana by a patient as that term is defined in OAR 333-008-0010, must submit the following information to the Authority:

(a) The number of mature marijuana plants and immature marijuana plants, the amount of marijuana leaves and flowers being dried, and the amount of usable marijuana, in the person's possession;

(b) The number of mature marijuana plants and immature marijuana plants, and the amount of usable marijuana transferred to each patient for whom the person produces marijuana, or that patient's designated primary caregiver during the previous month;

(c) The amount of usable marijuana transferred to each marijuana processing site during the previous month; and

(d) The number of immature marijuana plants, and the amount of usable marijuana transferred to each medical marijuana dispensary during the previous month.

(4) The information required to be submitted under this rule must be submitted electronically in a manner prescribed by the Authority.

(5) In addition to submitting the information as required in section (3) of this rule a person designated to produce marijuana by a patient must keep a record of the information described in section (3) of this rule for two years after the date on which the person submits the information to the Authority.

(6) A person designated to produce marijuana by a patient, as that term is defined in OAR 333-008-0010, may delegate his or her duty to report information under section (3) of this rule to another person designated to produce marijuana by a patient if the marijuana grow site addresses are the same.

(a) The person to whom the duty is delegated must submit a notice, on a form prescribed by the Authority, of the delegation.

(b) A delegation under this section does not relieve a person designated to produce marijuana by a patient, who delegates the duty to report, from complying with any of these rules, except for the duty to report.

(c) If a person to whom the reporting duty has been delegated fails to report in accordance with section (3) of this rule the Authority may suspend or revoke the registration of the person to whom the reporting duty was delegated.

(d) If the person to whom the reporting duty has been delegated fails to report in accordance with section (3) of this rule for any person designated to produce marijuana by a patient the delegation is void and the person who delegated the reporting duty must report the information to the Authority within 10 business days of being informed by the Authority of the failure to report.

Stat. Auth.: ORS 475B.420, 475B.423, 475B.525
Stats. Implemented: ORS 475B.420, 475B.423
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1000
Applicability

(1) A person may not establish, conduct, maintain, manage or operate an establishment for the purpose of providing the services in ORS 475B.450(1)(a) unless the person is registered by the Authority under these rules.

(2) Nothing in these rules exempts a dispensary registrant or dispensary representative from complying with any other applicable state or local laws.

(3) Registration of a dispensary does not protect a dispensary registrant or dispensary representative from possible criminal prosecution under federal law.

(4) Registration by the Authority is not a guarantee that a dispensary is permitted to operate under applicable land use or other local government laws where the dispensary is located.

(5) These rules apply to any initial or renewal application filed on or after June 24, 2016, and to any application filed prior to June 24, 2016 that the Authority has not approved or denied.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1020
Application for Medical Marijuana Dispensary Registration

(1) To register a medical marijuana dispensary a person must:

(a) Submit an initial application on a form prescribed by the Authority that includes but is not limited to:

(A) The name of the individual who owns the dispensary or, if a business entity owns the dispensary, the name of each individual who has a financial interest in the dispensary;

(B) The name of the individual or individuals responsible for the dispensary, if different from the name of the individual who owns the dispensary, with one of the individuals responsible for the dispensary identified as the primary PRD;

(C) The physical and mailing address of the medical marijuana dispensary; and

(b) Application and registration fee.

(2) An initial application for the registration of a dispensary must be submitted electronically via the Authority's website, www.healthoregon.org/ommp.

(3) If an initial application is submitted along with the required fees the Authority will notify the applicant in writing that the application has been received and that within 30 calendar days of the date the written notice is mailed the following information must be received by the Authority:

(a) For each individual named in the application:

(A) A legible copy of the individual's valid government issued photographic identification that includes last name, first name and date of birth;

(B) Information, fingerprints and fees required for a criminal background check in accordance with OAR 333-008-2020; and

(C) An Individual History Form and any information identified in the form that is required to be submitted;

(b) A written statement from an authorized official of the local government that the proposed location of the dispensary is not located in an area that is zoned for residential use as that term is defined in OAR 333-008-0010;

(c) Proof that the business is registered or has filed an application to register as a business with the Oregon Office of the Secretary of State, including proof of registration for any DBA (doing business as) registration;

(d) Documentation, in a format prescribed by the Authority that the proposed location of the dispensary is not within 1,000 feet of:

(A) The real property comprising a public or private elementary or secondary school, except as provided in Oregon Laws 2016, chapter 83, section 29; or

(B) A registered dispensary.

(e) A scaled site plan of the parcel on which the premises proposed for registration is located, including:

(A) Cardinal directional references;

(B) Bordering streets and the names of the streets;

(C) Identification of the building or buildings in which the proposed dispensary is to be located;

(D) The dimensions of the proposed premises of the dispensary;

(E) Identification of other buildings or property owned by or under the control of the applicant on the same parcel or tax lot as the premises proposed for registration that will be used in the business; and

(F) Identification of any residences on the parcel or tax lot; and

(f) A scaled floor plan of all enclosed areas of the premises at the proposed location that will be used in the business with clear identification of walls, partitions, counters, windows, all areas of ingress and egress, intended uses of all spaces and all limited access areas; and

(g) Documentation that shows the applicant has lawful possession of the proposed location of the dispensary.

(4) The documentation required in section (3) of this rule may be submitted electronically to the Authority or may be mailed to the Oregon Medical Marijuana Program, Oregon Health Authority, PO Box 14116, Portland, OR 97293.

(a) If documentation is mailed it must be received by the Authority within 30 calendar days of the date the Authority mailed the notice to the applicant that the initial application was received or the application will be considered incomplete.

(b) If documentation is submitted electronically it must be received by the Authority by 5 p.m. Pacific Time within 30 calendar days of the date the Authority mailed the notice to the applicant that the initial application was received. or the application will be considered incomplete.

(5) Application and registration fees must be paid online at the time of application.

(6) Criminal background check fees must be paid by check or money order and must be mailed to the Oregon Medical Marijuana Program, PO Box 14116, Portland, OR 97293, and must be received by the Authority in accordance with provisions in section (4) of this rule.

(7) If the Authority does not receive a complete application, including all documentation required in sections (1) and (3) of this rule, and all

required fees within the time frames established in this rule, the application will be considered incomplete.

(8) If an applicant provides the documentation required in section (3) of this rule the Authority will review the information to determine if it is complete.

(a) If the documentation is not complete or is insufficient the Authority must notify the applicant in writing and the applicant will have 10 calendar days from the date such written notice is mailed by the Authority to provide the additional documentation.

(b) If the applicant does not provide the additional documentation within 10 calendar days or if any responsive documents are incomplete, insufficient or otherwise do not demonstrate compliance with ORS 475B.450 and these rules the application will be declared incomplete.

(9) A person who wishes to register more than one location must submit a separate application, registration fees, and all documentation described in sections (1) and (3) of this rule for each location.

(10) An application that is incomplete is treated by the Authority as if it was never received.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1040
Dispensary Application Review

(1) Applications will be reviewed in the order they are received by the Authority. An application is considered received as of the date and time that payment of application and registration fees is authorized by the entity that issued the credit or debit card used to pay the fees.

(2) Once the Authority has determined that an application is complete it will review an application to the extent necessary to determine compliance with ORS 475B.450 and these rules.

(3) The Authority may, in its discretion, prior to acting on an application:

(a) Contact any individual listed on the application and request additional documentation or information;

(b) Inspect the premises of the proposed dispensary; or

(c) Verify any information submitted by the applicant.

(3) Prior to making a decision whether to approve or deny an application the Authority must:

(a) Review the criminal background check results for each individual named on the application;

(b) Determine whether the proposed location of the dispensary is the same location as a registered grow site under OAR 333-008-0025;

(c) Review documentation submitted by the applicant to determine, based on the information provided by the applicant, whether the proposed location of the dispensary is located within 1,000 feet of:

(A) The real property comprising a public or private elementary or secondary school, except as provided in Oregon Laws 2016, chapter 83, section 29; or

(B) Another registered dispensary;

(d) Verify that the applicant is registered as a business with the Office of the Secretary of State; and

(e) Verify that the proposed location of the dispensary is not:

(A) Located in an area that is zoned for residential use; or

(B) In a city or county that has adopted an ordinance under ORS 475B.800 or section 133 chapter 614, Oregon Laws 2015, prohibiting dispensaries.

(4) If during the review process the Authority determines that the application or supporting documentation contains intentionally false or misleading information the Authority may declare the application incomplete or issue a notice of denial under OAR 333-008-1060.

(5) The Authority will notify the applicant in writing that the applicant has 60 calendar days from the date of the written notice to submit a Readiness Form, prescribed by the Authority, indicating that the applicant is prepared for an inspection and is in compliance with these rules if:

(a) There is no basis for denial under OAR 333-008-1060;

(b) The proposed dispensary is in compliance with ORS 475B.450(3)(a) through (e);

(c) Each individual named in the application passes the criminal background check; and

(d) Each individual named as a PRD in the application meets age requirements.

(6) If the Authority does not receive the Readiness Form in accordance with section (5) of this rule the applicant's application will be declared incomplete, unless an extension has been granted under section (7) of this rule.

(7) An applicant may request one extension of the 60-day deadline in section (5) of this rule if the applicant can demonstrate to the Authority that the deadline cannot be met for reasons outside of the applicant's control, such as but not limited to the applicant's inability to obtain local government building permits.

(a) A request for an extension must be in writing, must be received within 60 calendar days of the notice described in section (5) of this rule and must explain and provide documentation that shows the applicant cannot, for reasons outside of the applicant's control, meet the 60-day deadline, and must specify when the applicant believes it can submit the Readiness Form.

(b) A request for an extension tolls the 60-day deadline.

(c) The Authority will review the request and provide, in writing to the applicant, its decision and the reason for the decision.

(d) If an extension is granted the Authority must inform the applicant of the new deadline for submission of the Readiness Form, but in any case an extension may not exceed 60 calendar days.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1060
Denial of Dispensary Application

(1) The Authority must deny an application if:

(a) An application, supporting documentation provided by the applicant, or other information obtained by the Authority shows that the qualifications for a dispensary in ORS 475B.450 or these rules have not been met; or

(b) An individual named in an application has been:

(A) Convicted for the manufacture or delivery of a controlled substance in Schedule I or Schedule II within two years from the date the application was received by the Authority; or

(B) Convicted more than once for the manufacture or delivery of a controlled substance in Schedule I or Schedule II; or

(c) The city or county in which the facility is located has prohibited dispensaries in accordance with sections 133 chapter 614, Oregon Laws 2015, or ORS 475B.800, unless the dispensary meets the criteria in sections 133(6), chapter 614, Oregon Laws 2015 or ORS 475B.800(6).

(2) The Authority may deny an applicant if it determines that the applicant, the owner of the dispensary, a PRD, or an employee of the medical marijuana dispensary:

(a) Submitted intentionally false or misleading information to the Authority; or

(b) Violated at any time a provision of ORS 475B.400 to 475B.525, 475B.555, 475B.605, 475B.615, OAR chapter 333, division 7, these rules or an ordinance adopted pursuant to ORS 475B.500.

(3) If an individual named in an application is not qualified based on age or the criminal background check, the Authority will permit a change form to be submitted in accordance with OAR 333-008-1078 or 333-008-2030, along with the applicable criminal background check fee. If the individual named in the change form is not qualified the Authority must deny the application in accordance with section (1) of this rule.

(4) If the Authority intends to deny an application for registration it must issue a Notice of Proposed Denial in accordance with ORS 183.411 through 183.470.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 16-2015(Temp), f. & cert. ef. 9-22-15 thru 3-19-16; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1070
Expiration and Renewal of Dispensary Registration

(1) A dispensary's registration expires one year following the date of application approval.

(2) A dispensary registrant must submit not more than 90 but at least 30 calendar days before the registration expires:

(a) A renewal application on a form prescribed by the Authority;

(b) Renewal fees;

(c) For each individual named in the renewal application:

(A) A legible copy of the individual's valid government issued photographic identification that includes last name, first name and date of birth;

(B) Information, fingerprints and fees required for a criminal background check in accordance with OAR 333-008-2020;

(C) An Individual History Form and any information identified in the form that is required to be submitted;

(d) Current proof of business registration with the Secretary of State, including all DBA (doing business as) registrations;

(e) Documentation that shows the applicant has lawful possession of the location of the registered dispensary; and

Any information required during an initial application; and

(f) A current scaled floor plan of all enclosed areas at the registered dispensary that are used in the business with clear identification of walls, partitions, counters, windows, all areas of ingress and egress, and all limited access areas.

(3) A registrant who files a completed renewal application with the Authority prior to the expiration date of the registration may continue to operate, even after the registration expiration date, pending a decision on the renewal application by the Authority.

(4) A dispensary registrant that does not submit timely renewal documentation in accordance with sections (1) and (2) of this rule may be subject to the imposition of civil penalties.

(5) If a dispensary registrant does not submit all the forms, fees and information required in section (2) of this rule prior to the registration's expiration, the registration is expired and is no longer valid.

(6) Renewals will be processed in accordance with OAR 333-008-1040 to 333-008-1060, as applicable.

(7) A renewal applicant may be required to submit a Readiness Form, as described in OAR 333-008-1040 and may be subject to inspection prior to the Authority acting on a renewal application.

(8) For purposes of this rule a completed application shall be deemed submitted upon receipt by the Authority of all application forms, supporting documents and renewal fees described in section (2) of this rule.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 16-2015(Temp), f. & cert. ef. 9-22-15 thru 3-19-16; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1075
PRD Criteria and Responsibilities

(1) A PRD must:

(a) Be 21 years or age or older;

(b) Have legal authority to act on behalf of the dispensary; and

(c) Be responsible for ensuring the registered dispensary complies with applicable laws.

(2) A PRD may not:

(a) Have been convicted in any state for the manufacture or delivery of a controlled substance in Schedule I or Schedule II within two years from the date of application; or

(b) Have been convicted more than once in any state for the manufacture or delivery of a controlled substance in Schedule I or Schedule II.

(3) At least one PRD must be on site at a dispensary during Authority inspections or investigations at the time of the inspection or investigation or within one hour of being notified that an inspection or investigation is taking place.

(4) A PRD is accountable for any intentional or unintentional action of registrant representatives, with or without the knowledge of the PRD, who violate ORS 475B.450, 475B.453 or these rules, and is responsible for any unlawful conduct that occurs on the premises of the dispensary or any property outside the registered dispensary that is owned by or under the control of the dispensary registrant.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1078
Removal, Addition, Change, Designation or Assignment of PRD

(1) If an owner of a registered dispensary is adding or changing a PRD or primary PRD, an individual with legal authority to act on behalf of the registered dispensary must submit:

(a) A form, prescribed by the Authority;

(b) A legible copy of the individual's valid government issued photographic identification that includes last name, first name and date of birth;

(c) Information and fingerprints required for a criminal background check in accordance with OAR 333-008-2020; and

(d) A criminal background check fee of $35.

(2) A PRD who is designating or assigning the responsibilities of a PRD to another individual must submit the information and fees required in section (1) of this rule. The responsibilities of a primary PRD may not be designated or assigned.

(3) The Authority will review and approve the addition or change of a PRD or primary PRD if the individual meets the requirements in OAR 333-008-1075.

(4) The Authority will review and approve the designation or assignment of the responsibilities of a PRD to another individual if that individual meets the requirements in OAR 333-008-1075. An individual to whom a designation or assignment is made, and who is approved by the Authority, has the same legal obligations as a PRD.

(5) An individual may not act in the capacity of a PRD without approval from the Authority.

(6) If the Authority denies the request to add or change a PRD or primary PRD, or denies the request to designate or assign the responsibilities of a PRD to another individual, the Authority must notify the individual that submitted the request of the denial and the current primary PRD, and describe the reason for the denial.

(7) A registered dispensary may not be open for business or receive or transfer any marijuana items without at least one Authority approved PRD and a primary PRD.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1110
Locations of Medical Marijuana Dispensaries; Dispensary Premises Restrictions and Requirements

(1) A dispensary may not be located:

(a) In an area that is zoned for residential use.

(b) At the same address as a registered marijuana grow site;

(c) Within 1,000 feet of the real property comprising a public or private elementary or secondary school, except as provided in Oregon Laws 2016, chapter 83, section 29; or

(d) Within 1,000 feet of another medical marijuana dispensary.

(2) For purposes of implementing ORS 475B.450(3)(d), the Authority will consider a location to be a school if it has at least the following characteristics:

(a) Is a public or private elementary or secondary school as those terms are defined OAR 333-008-0010;

(b) There is a building or physical space where students gather together for education purposes on a regular basis;

(c) A curriculum is provided;

(d) Attendance is compulsory under ORS 339.020 or children are being taught as described in ORS 339.030(1)(a); and

(e) Individuals are present to teach or guide student education.

(3) For purposes of determining the distance between a dispensary and a school "within 1,000 feet" means a straight line measurement in a radius extending for 1,000 feet or less in any direction from the closest point anywhere on the boundary line of the real property comprising an existing public or private elementary or secondary school to the closest point of the premises of a dispensary. If any portion of the premises of a proposed or registered dispensary is within 1,000 feet of a public or private elementary or secondary school it may not be registered.

(4) For purposes of determining the distance between a dispensary and another registered dispensary "within 1,000 feet" means a straight line measurement in a radius extending for 1,000 feet or less in every direction from the closest point anywhere on the premises of a registered dispensary to the closest point anywhere on the premises of a proposed dispensary. If any portion of the premises of a proposed dispensary is within 1,000 feet of a registered dispensary it may not be registered.

(5) In order to be registered a dispensary must operate at a particular location as specified in the application and may not be mobile.

(6) Minors on Premises. A dispensary registrant may not permit a minor to be present in any limited access or point of sale area of a registered dispensary.

(7) On Premises Consumption.

(a) A dispensary registrant may not permit the ingestion, inhalation or topical application of a marijuana item anywhere on the premises of the registered dispensary, except as described in subsection (b) of this section.

(b) An employee of a registered dispensary who is a patient may consume a marijuana item during his or her work shift on the premises of the registered dispensary as necessary for his or her medical condition, if the employee is:

(A) Alone and in a closed room where no dispensary marijuana items are present;

(B) Not visible to patients or caregivers on the premises of the registered dispensary to receive a transfer of a marijuana item; and

(C) Not visible to the public outside the dispensary.

(c) For purposes of this section consume does not include smoking, combusting, inhaling, vaporizing, or aerosolizing a marijuana item.

(8) General Public and Visitor Access. The general public is not permitted on the premises of a registered dispensary, except as permitted by OAR 333-008-1500 and in accordance with this rule.

(a) In addition to registrant representatives, the following visitors are permitted on the premises of a dispensary, including limited access areas, subject to the requirements in section (9) of this rule:

(A) Laboratory personnel, if the laboratory is accredited by the Authority;

(B) A contractor authorized by a registrant representative to be on the premises; or

(C) Individuals authorized to transfer marijuana items to a registered dispensary.

(b) A registered dispensary may permit up to seven invited guests 21 years of age and older, per week, on the premises of a registered dispensary, including limited access areas, subject to the requirements in section (9) of this rule.

(9) Visitor Escort, Log and Badges.

(a) Prior to entering the premises of a registered dispensary all visitors permitted by section (8) of this rule must be documented and issued a visitor identification badge from a registrant representative that must remain visible while on the premises. All visitors described in section (8) of this rule must be accompanied by a registrant representative at all times.

(b) A dispensary registrant must maintain a log of all visitor activity and the log must contain the first and last name and date of birth of every visitor, and the date they visited.

(10) Government Access. Nothing in this rule is intended to prevent or prohibit Authority employees or contractors, or other state or local government officials that have jurisdiction over some aspect of the premises or a dispensary registrant to be on the premises.

(a) A visitor badge is not required for government officials.

(b) A dispensary must log every government official that enters the premises but the dispensary may not request that the government official provide a date of birth for the log.

(11) Limited Access Areas.

(a) All limited access areas must be physically separated from any area where the general public is permitted, by a floor to ceiling wall that prevents physical access between a point of sale area and an area that is open to the general public except through a door that is kept locked by a dispensary when the door is not immediately in use.

(b) An applicant or registered dispensary may request, in writing, an exception from the Authority from the requirement to have a floor to ceiling wall. The request must include the reason the exception is being sought, pictures of the area in question, and a description of an alternative barrier that accomplishes the goal of providing a significant physical barrier between the general public and any marijuana items on the premises of the dispensary.

(12) A dispensary must have:

(a) A designated limited access area or areas where transfers of marijuana items are received and such an area may not be accessible to patients or designated primary caregivers on the premises to receive the transfer of a marijuana item or the general public; and

(b) A designated area within the premises where patients and designated primary caregivers and other visitors enter the dispensary and are checked in.

(13) The areas described in section (12) of this rule must be clearly marked on the floor or plot plan sketch required in OAR 333-008-1040.

(14) Point of Sale Areas.

(a) All point of sale areas must be physically separated from any area where the general public is permitted by a floor to ceiling wall that prevents physical access between a point of sale area and an area that is open to the general public except through a door that is kept locked by a dispensary when the door is not immediately in use.

(b) All areas where marijuana items are available for transfer to a patient or designated primary caregiver must be supervised by a dispensary representative at all times when a patient or designated primary caregiver is present.

(c) A dispensary may not transfer a marijuana item to a patient or designated primary caregiver through a drive-through window.

(15) A dispensary may not sublet or share with any other business any portion of the dispensary premises.

Stat. Auth.: ORS 475B.450 & 475B.525

Stats. Implemented: ORS 475B.450

Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1190

Testing

(1) This rule is in effect until October 1, 2016.

(a) Nothing in this rule prohibits a dispensary or an accredited laboratory from complying with the testing rules in OAR 333-007-0300 to 333-007-0490 and providing or accepting a test result that is in compliance with OAR 333-064-0100 and 333-064-0110 in lieu of a test result required in this rule.

(b) Nothing in this rule prohibits an accredited laboratory from performing sampling and testing for a registrant in accordance with this rule, prior to October 1, 2016.

(2) For purposes of this rule:

(a) "Batch" has the same meaning given that term in OAR 333-007-0310.

(b) "TNI" has the same meaning given that term in OAR 333-007-0310.

(c) "TNI standards" has the same meaning given that term in OAR 333-007-0310.

(3) Prior to being registered a PRD must have documentation that identifies at least one laboratory that will do the testing in accordance with this rule.

(4) A registered dispensary may only accept laboratory test results from a laboratory on the Authority's list posted on the Authority's website, www.healthoregon.org/ommp.

(5) A PRD must have a test report that complies with section (11) of this rule that can be linked to the batch from which each sample was taken and to each marijuana item available for transfer, before the marijuana item is available for transfer to a patient or a designated primary caregiver.

(6) A registered dispensary may submit samples for testing in accordance with section (7) of this rule or a PRD may accept test results if:

(a) A copy of the test results is obtained at the time of transfer that clearly links the test results to the marijuana item being transferred;

(b) The PRD can demonstrate to the Authority that random samples from the batch were taken and submitted for testing; and

(c) The PRD can demonstrate to the Authority that the batch from where samples were taken was sealed and not tampered with from the time samples for testing were taken and when they were delivered to the dispensary.

(7) Prior to October 1, 2016, if a dispensary accepts the transfer of a marijuana item that has not been tested in accordance with this rule a dispensary representative must:

(a) Segregate each untested batch and place the batch in an individual container or bag with a label attached to the container or bag that includes at least the following information:

(A) A unique identifier;

(B) The name of the product;

(C) The name of the person who transferred the marijuana item;

(D) The date the marijuana item was received; and

(E) "PRODUCT NOT TESTED" in bold, capital letters, no smaller than 12 point font.

(b) Take random samples from each batch in an amount necessary to conduct the applicable test, label each sample with the batch's unique identifier, and submit the samples for testing.

(c) Once samples have been taken for the purpose of testing, store and secure the untested item in a manner that prevents the item from being tampered with or transferred prior to test results being reported.

(8) Pesticide Testing. A marijuana item, except for seeds and immature plants, must be tested for pesticides by testing for individual pesticides (analytes) in the following categories, using valid testing methodologies:

(a) Chlorinated Hydrocarbons;

(b) Organophosphates;

(c) Carbamates; and

(d) Pyrethroid.

(9) THC and CBD Testing. A marijuana item, except for seeds and immature plants, must be tested to determine the levels of THC and CBD using valid testing methodologies.

(10) Laboratory Requirements. A PRD must be able to show that the laboratory that conducted the testing required in this rule:

(a) Uses valid testing methodologies; and

(b) Has a Quality System for testing of pesticides that is compliant with the:

(A) 2005 International Organization for Standardization 17025 Standard; or

(B) 2009 National Environmental Laboratory Accreditation Conference Institute TNI Standards.

(11) Testing Results. A laboratory test result must:

(a) Comply with the standards in TNI 2009, Volume 1, Module 2, Section 5.10, incorporated by reference.

(b) Include the following information:

(A) The name of each specific analyte tested;

(B) The limit of quantitation (LOQ) as that is defined in TNI 2009, Volume 1, Module 2, Section 3.1 and TNI 2009, Volume 1, Module 4, Section 1.5, incorporated by reference;

(C) The pesticide results as a numerical value in units of either parts per million or parts per billion if the analyte was detected or a statement that the level detected was less than the LOQ;

(D) The levels of THC and CBD calculated in accordance with OAR 333-064-0100; and

(E) The quality control results from the blank and quality control samples associated with the sample testing.

(c) Be signed by an official of the laboratory with an attestation that the results are accurate and that testing was done using valid testing methodologies and a quality system as required in this rule.

(12) A sample of a marijuana item shall be deemed to test positive for pesticides with a detection of more than 0.1 parts per million of any pesticide.

(13) If a marijuana item tests positive for pesticides based on the standards in this rule the PRD must:

(a) Return the entire batch from which the sample was taken to the individual who transferred the marijuana item to the dispensary and document how many or how much was returned, to whom, and the date it was returned; or

(b) Dispose of the entire batch in a manner specified by the Authority.

(14) The PRD may permit laboratory personnel or other persons authorized to do testing access to secure or restricted access areas of the dispensary where marijuana items are stored. A dispensary representative must log the date and time in and out of all such persons.

(15) If the Authority determines that a laboratory is not using valid testing methodologies, does not have a quality system, or is not producing test result reports in accordance with this rule the Authority may remove the name of the laboratory from the list on the Authority's website.

(16) The Authority may do audit testing of a marijuana item in order to determine whether a dispensary is in compliance with this rule.

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

Stat. Auth.: ORS 475B.450 & 475B.525

Stats. Implemented: ORS 475B.450

Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 8-2014(Temp), f. 2-19-14, cert. ef. 2-21-13 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1200

Operation of Registered Dispensaries

(1) Policies and Procedures. In order to obtain a registration and to retain registration a dispensary registrant must have written detailed policies and procedures and training for employees on the policies and procedures that, at a minimum, cover the following:

(a) Security;

(b) Transfers of marijuana items to and from the dispensary;

(c) Operation of a registered dispensary;

(d) Required record keeping;

(e) Testing requirements;

(f) Packaging and labeling requirements;

(g) Employee training;

(h) Compliance with these rules, including but not limited to violations and enforcement; and

(i) Roles and responsibilities for employees and PRDs in assisting the Authority during inspections or investigations..

(2) Employees. A registered dispensary may employ an individual between the ages of 18 and 20 if the individual is a patient. Otherwise, dispensary employees must be 21 years of age or older.

(3) Standardized Scales. In order to obtain a registration and to retain registration a dispensary registrant must own, maintain on the premises and use a weighing device that is licensed by the Oregon Department of Agriculture. Licensed weighing devices must be used by a registered dispensary whenever marijuana items are:

(a) Transferred to or from the dispensary and the transfer is by weight;

(b) Packaged for transfer by weight; or

(c) Weighed for purposes of documenting information required in OAR 333-008-1230, 333-008-1245, 333-008-1247 and 333-008-1248.

(4) Inventory Tracking and Point of Sale System: In order to obtain a registration and to retain registration a registered dispensary must have an installed and fully operational integrated inventory tracking and point of sale system that can and does, at a minimum:

(a) Produce bar codes or similar unique identification numbers for each marijuana item lot transferred to a registered dispensary;

(b) Trace back or link each transfer of a marijuana item to a patient or caregiver to the marijuana item lot;

(c) Capture all information electronically that is required to be documented in OAR 333-008-1230 and 333-008-1245;

(d) Generate inventory, transaction, and transfer reports viewable in excel format; and

(e) Produce all the information required to be submitted to the Authority pursuant to OAR 333-0080-1248.

(5) Online Verification of Registration Status. A dispensary must verify an individual's registration status with the Authority when receiving or making the transfer of a marijuana item if the Authority has available an online system for such verification.

(6) Inventory On-Site. Marijuana items must be kept on-site at the dispensary. The Authority may take enforcement action against a dispensary registrant if during an inspection a dispensary registrant cannot account for its inventory or if the amount of usable marijuana at the registered dispensary is not within five percent of the documented inventory.

(7) Testing. On and after October 1, 2016, a dispensary registrant may not:

(a) Accept a transfer of a marijuana item that has not been tested in accordance with OAR 333-007-0300 to 333-007-0490.

(b) Transfer a marijuana item that has not been tested in accordance with OAR 333-007-0300 to 333-007-0490 unless it is labeled in accordance with OAR 333-007-0300.

(8) Packaging and Labeling. On and after October 1, 2016, a dispensary may not accept a transfer of a marijuana item or transfer a marijuana item that does not comply with the labeling requirements in OAR 333-007-0010 to 333-007-0100, or that does not comply with the packaging requirements in OAR 845-025-7000 to 845-025-7020 and 845-025-7060.

(9) Oregon Department of Agriculture Licensure. On and after October 1, 2016, a registered dispensary that sells or handles food, as that term is defined in ORS 616.695, or cannabinoid edibles, must be licensed by the Oregon Department of Agriculture under ORS 616.706.

(10) Industrial Hemp Products.

(a) A dispensary may only accept the transfer of and may only transfer a product that contains THC or CBD that is derived from marijuana.

(b) Nothing in this section prohibits a dispensary from buying or selling hemp products not intended for human application, consumption, inhalation, ingestion, or absorption, such as hemp clothing.

(11) Tobacco. A dispensary may not offer or sell tobacco products in any form including, but not limited to, loose tobacco, pipe tobacco, cigarettes as defined in ORS 323.010 and cigarillos as that is defined in OAR 333-015-0030.

(12) For purposes of this rule "marijuana item lot" means a quantity of seeds, immature plants, usable marijuana, medical cannabinoid products, concentrates or extracts transferred to a registered dispensary at one time and that is from the same harvest lot or process lot as those terms are defined in OAR 333-007-0020.

Stat. Auth.: ORS 475B.450 & 475B.525

Stats. Implemented: ORS 475B.450

Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1205

Registered Dispensary Signage

(1) In order to obtain a registration and to retain registration a dispensary registrant must post:

(a) At every entrance to the dispensary:

(A) If a dispensary does not participate in limited marijuana retail sales a sign that reads "Medical Marijuana Patients Only";

(B) If a dispensary is permitted to sell limited marijuana retail products in accordance with OAR 333-008-1500, signs that comply with OAR 333-008-1500 and 333-008-1501(1)(b); and

(C) "No On-Site Consumption of Marijuana".

(b) At all areas of ingress to a limited access area signs that reads:

(A) "Restricted Access Area — Authorized Personnel Only".

(B) "No Minors Allowed".

(c) At all areas of ingress to a point of sale area a sign that reads: "Restricted Access Area — No Minors Allowed".

(d) At the point of sale, the following posters prescribed by the Authority, measuring 22 inches high by 17 inches wide that can be downloaded at www.healthoregon.org/ommp:

(A) A Pregnancy Warning Poster; and

(B) A Poisoning Prevention Poster.

(2) All signs required by this rule must be:

(a) Legible, not less than 8 1/2 inches by and 11 inches, composed of letters not less than one-half inch in height;

(b) In English and Spanish, if a Spanish version is available through the Authority; and

(c) Posted in a conspicuous location where the signs can be easily read by individuals entering or on the dispensary premises.

(3) All signs may be downloaded at www.healthoregon.org/ommp.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1225
Packaging

(1) This rule is in effect from March 1, 2016 until October 1, 2016. Nothing in this rule prohibits a dispensary from complying with the packaging rules in OAR 845-025-7000 to 845-025-7060 prior to October 1, 2016.

(2) For purposes of this rule:

(a) "Child-resistant safety packaging" means:

(A) Containers designed and constructed to be significantly difficult for children under five years of age to open and not difficult for adults to use properly;

(B) Closable for any product intended for more than a single use or containing multiple servings; and

(C) Labeled in accordance with OAR 333-008-1220.

(b) "Container" means a sealed, hard or soft-bodied receptacle in which a tetrahydrocannabinol-infused product is placed prior to being transferred to a patient or caregiver.

(c) "Packaged in a manner not attractive to minors" means the tetrahydrocannabinol-infused product is not in a container that is brightly colored, depicts cartoons or images other than the logo of the facility, unless the logo of the facility depicts cartoons, in which case only the name of the facility is permitted.

(3) A dispensary may not transfer a medical cannabinoid product, extract or concentrate to a patient or caregiver unless the product, extract or concentrate is in child-resistant safety packaging.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 9-2014(Temp), f. & cert. ef. 4-1-14 thru 9-27-14; PH 25-2014, f. & cert. ef. 9-24-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 13-2016(Temp), f. 4-13-16, cert. ef. 4-15-16 thru 9-30-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1230
Transfers to a Registered Dispensary

(1) Transfer of Usable Marijuana, Seeds and Immature Plants. A patient, caregiver, or PRMG may transfer usable marijuana, seeds and immature plants produced by a PRMG to a registered dispensary, subject to the requirements in this rule.

(a) A registered dispensary may only accept a transfer of usable marijuana, seeds or immature marijuana plants from a caregiver or PRMG if the individual transferring the usable marijuana, seeds or immature plants provides the original or a copy of a valid:

(A) Authorization to Transfer form prescribed by the Authority; or

(B) Personal agreement as that is defined in OAR 333-008-0010.

(b) Authorization to Transfer Forms. In order to be valid an Authorization to Transfer form must include at least:

(A) The patient's name, OMMP card number or receipt number and expiration date and contact information;

(B) The name and contact information of the individual who is authorized to transfer the usable marijuana, seeds or immature marijuana plants to the registered dispensary and that individual's OMMP card number and expiration date;

(C) The name and address of the registered dispensary that is authorized to receive the usable marijuana, seeds or immature marijuana plants; and

(D) The date the authorization expires, if earlier than the expiration date of the patient's OMMP card.

(c) Personal Agreements. In order to be valid a personal agreement must include at least:

(A) The patient's name, OMMP card number and expiration date and contact information;

(B) The name and contact information of the PRMG to whom the patient's property rights have been assigned and the producer's OMMP card number and expiration date, and the grow site address;

(C) The portion of the patient's rights to possess seeds, immature plants and usable marijuana that is being assigned to the producer.

(2) Transfer of medical cannabinoid products, concentrates, and extracts.

(a) Until October 1, 2016, a registered dispensary may accept the transfer of a cannabinoid product or concentrate from a patient, caregiver or PRMG in accordance with section (1) of this rule.

(b) On and after October 1, 2016, a registered dispensary may only accept a transfer of a medical cannabinoid product, concentrate or extract from a registered medical marijuana processing site.

(c) Until October 1, 2016, a registered dispensary may accept the transfer of a medical cannabinoid extract from a marijuana processing site.

(3) A registered dispensary may only accept a transfer of cannabinoid products, concentrates or extracts from registered processing site if the individual transferring the products, concentrates or extracts provides the dispensary with a Processing Site Authorization to Transfer form prescribed by the Authority. In addition to retaining a copy of the Processing Site Authorization to Transfer form the dispensary must obtain a copy of the photo identification of the individual transferring the cannabinoid product, concentrate or extract as required in section (4)(b)(B) of this rule.

(4) Transfer Records. At the time a marijuana item is transferred to a dispensary the dispensary registrant must:

(a) Document, as applicable:

(A) The weight in metric units of all usable marijuana received by the registered dispensary;

(B) The number of seeds and immature plants received by the registered dispensary;

(C) The amount of a medical cannabinoid product, concentrate, or extract received by the registered dispensary, including, as applicable, the weight in metric units, or the number of units;

(D) The name of the marijuana item;

(E) The date the marijuana item was received; and

(F) The amount of reimbursement paid by the registered dispensary.

(b) Obtain and maintain a copy of, as applicable:

(A) Documents required in section (1) of this rule including the date it was received;

(B) The photo identification of the individual transferring the marijuana item to the dispensary, if such a copy is not already on file;

(C) The OMMP card of the individual transferring usable marijuana, seeds or immature plants;

(D) The medical marijuana processing site registration; and

(E) Test results for marijuana items transferred to the dispensary unless the dispensary plans to arrange for the testing of the marijuana item.

(5) Prior to October 1, 2016, if a dispensary accepts the transfer of a marijuana item that has not been tested in accordance with OAR 333-007-0300 to 333-007-0490 the dispensary must comply with OAR 333-008-1190(7).

(6) Once a marijuana item has been sampled in accordance with OAR 333-007-0360 the marijuana item must be labeled and stored in accordance with OAR 333-007-0380.

(7) Nothing in these rules requires a dispensary registrant to accept a transfer of a marijuana item.

(8) All documentation required in this rule must be maintained electronically in an integrated inventory tracking and point of sale system or the electronic data management system described in OAR 333-008-1247.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 2-2014(Temp), f. 1-14-14, cert. ef. 1-15-14 thru 7-13-14; PH 20-2014, f. & cert. ef. 7-11-14; PH 4-2015, f. & cert. ef. 1-28-15; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1245
Transfers From a Registered Dispensary to a Patient or Designated Primary Caregiver

(1) A dispensary registrant must, prior to permitting an individual to enter a point of sale area on the dispensary premises, except as permitted under OAR 333-008-1500, verify that the individual is a current patient or designated primary caregiver.

(2) A registered dispensary must, prior to transferring a marijuana item to a patient or a designated primary caregiver:

(a) Verify the individual is currently registered with the Authority by viewing the individual's government issued photo identification and Authority issued patient or caregiver card, or the patient's receipt, as described in OAR 333-008-0023(6) or OAR 333-008-0040(5) and making sure the identities match.

(b) Obtain and retain, if not already on file, a copy of the patient's or caregiver's:

(A) OMMP identification card or receipt; and

(B) Government issued photo identification.

(c) Document:

(A) The name, OMMP card number and expiration date of the card of each person to whom the registered facility transfers a marijuana item;

(B) If the marijuana item was transferred to a designated primary caregiver, the patient's name and registration number for whom the caregiver was receiving the transfer;

(C) The amount of usable marijuana transferred in metric units, if applicable;

(D) The number of seeds or immature plants transferred, if applicable;

(E) The amount of a medical cannabinoid product concentrate, or extract, if applicable;

(F) The brand name of the marijuana item and a description of what was transferred;

(G) The date of the transfer; and

(H) The amount of money paid by the patient or designated primary caregiver for the transfer.

(3) A dispensary registrant may not transfer at any one time to a patient or designated primary caregiver, within one day, more than:

(a) 24 ounces of usable marijuana;

(b) 16 ounces of a medical cannabinoid product in solid form;

(c) 72 ounces of a medical cannabinoid product in liquid form;

(d) 16 ounces of a cannabinoid concentrate whether sold alone or contained in an inhalant delivery system;

(e) Five grams of a cannabinoid extract whether sold alone or contained in an inhalant delivery system;

(f) Four immature marijuana plants; and

(g) 50 seeds.

(4) All documentation required in this rule must be maintained electronically in an integrated inventory tracking and point of sale system or the electronic data management system described in OAR 333-008-1247.

Stat. Auth.: ORS 475B.450 & 475B.525
Stats. Implemented: ORS 475B.450
Hist.: PH 9-2014(Temp), f. & cert. ef. 4-1-14 thru 9-27-14; PH 25-2014, f. & cert. ef. 9-24-14; PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1610
Definitions

For purposes of OAR 333-008-1600 to 333-008-2200:

(1) "Cannabinoid capsule" means a small soluble container, usually made of gelatin, that encloses a dose of a cannabinoid product, concentrate or extract intended for human ingestion.

(2) "Cannabinoid edible" means a food or potable liquid into which a cannabinoid concentrate or extract or the dried leaves or flowers of marijuana have been incorporated.

(3) "Cannabinoid suppository" means a small soluble container designed to melt at body temperature within a body cavity other than the mouth, especially the rectum or vagina, containing a cannabinoid product, concentrate or extract.

(4) "Cannabinoid tincture" means a solution of alcohol, cannabinoid concentrate or extract, and perhaps other ingredients intended for human consumption or ingestion, and that is exempt from the Liquor Control Act under ORS 471.035.

(5) "Cannabinoid topical" means a cannabinoid product intended to be applied to skin or hair.

(6) "Cannabinoid transdermal patch" means an adhesive substance applied to human skin that contains a cannabinoid product, concentrate or extract for absorption into the bloodstream.

(7) "Food" means a raw, cooked, or processed edible substance, beverage or ingredient used or intended for use or for sale in whole or in part for human consumption, or chewing gum.

(8) "Person responsible for the marijuana processing site" or "PRP" means an individual who is directly involved in the day-to-day operation of a processing site and is identified as a PRP on an application.

(9) "Primary PRP" means a PRP designated by the owner of the processing site as the primary point of contact for the Authority and who is authorized to receive any and all communications and legal notices from the Authority.

(10) "Processing site representative" means an owner, director, officer, PRP, manager, employee, agent or other representative of a registered processing site, to the extent that the person acts in a representative capacity.

(11) "Processing site registrant" means:

(a) An individual who owns a registered processing site or if a business entity owns the registered processing site, each individual who has a financial interest in the registered processing site; and

(b) Any PRP.

(12) "These rules" means OAR 333-008-1600 to 333-008-2200.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1620
Application for Medical Marijuana Processing Site Registration

(1) This rule applies to any initial application filed on or after June 24, 2016 and to any initial application filed prior to June 24, 2016 that the Authority has not yet approved or denied.

(2) To register a medical marijuana processing site a person must:

(a) Submit an initial application on a form prescribed by the Authority that includes but is not limited to:

(A) The name of the individual who owns the processing site or, if a business entity owns the processing site, the name of each individual who has a financial interest in the processing site;

(B) The name of the individual or individuals responsible for the processing site, if different from the name of the individual who owns the processing site, with one of the individuals responsible for the processing site identified as the primary PRP;

(C) The address of the marijuana processing site; and

(b) Application and registration fees.

(c) An initial application for the registration of a processing site must be submitted electronically via the Authority's website, www.healthoregon.org/ommp.

(3) If an initial application is submitted along with the required fees the Authority will notify the applicant that the initial application has been received and that within 30 calendar days the following information must be received by the Authority:

(a) For each individual named in the application:

(A) A legible copy of the individual's valid government issued photographic identification that includes last name, first name and date of birth;

(B) Information, fingerprints and fees required for a criminal background check in accordance with OAR 333-008-2020; and

(C) An Individual History Form and any information identified in the form that is required to be submitted.

(b) If the applicant intends to process extracts, proof from the local government that the proposed location of the processing site is not located in an area that is zoned for residential use;

(c) Proof that the business is registered or has filed an application to register as a business with the Oregon Office of the Secretary of State, including proof of registration of any DBA (doing business as) registration;

(d) A scaled site plan of the parcel or premises on which the premises proposed for registration, is located, including:

(A) Cardinal directional references;

(B) Bordering streets and the names of the streets;

(C) Identification of the building or buildings in which the proposed processing site is to be located;

(D) The dimensions of the proposed premises of the processing site;

(E) Identification of other buildings or property owned by or under the control of the applicant on the same parcel or tax lot as the premises proposed for registration that will be used in the business; and

(F) Identification of any residences on the parcel or tax lot;.

(e) A scaled floor plan of all enclosed areas of the premises at the proposed location that will be used in the business with clear identification of walls, partitions, counters, windows, all areas of ingress and egress, intended uses of all spaces;

(f) Documentation that shows the applicant has lawful possession of the proposed location of the processing site;

(g) A description of the type of products to be processed, a description of equipment to be used, including any solvents, gases, chemicals or other compounds used to create extracts or concentrates on a form prescribed by the Authority; and

(h) The proposed endorsements as described in OAR 333-008-1700.

(4) The information and documentation required in section (3) of this rule may be submitted electronically to the Authority or may be mailed to the Oregon Medical Marijuana Program, Oregon Health Authority, PO Box 14116, Portland, OR 97293.

(a) If documentation is mailed, it must be received by the Authority within 30 calendar days of the date the Authority mailed the notice to the applicant that the application was received or the application will be considered incomplete.

(b) If documentation is submitted electronically it must be received by the Authority within 30 calendar days of the date the Authority mailed the notice to the applicant that the application was received or the application will be considered incomplete.

(5) Application and registration fees must be paid online at the time of application.

(6) Criminal background check fees must be paid by check or money order and must be mailed to the Oregon Medical Marijuana Program, Oregon Health Authority, PO Box 14116, Portland, OR 97293 and must be received by the Authority in accordance with provisions in section (4) of this rule.

(7) If the Authority does not receive a complete application, all documentation required in sections (2) and (3) of this rule, and all required fees within the time frames established in this rule, the application will be considered incomplete.

(8) If the applicant provides the documentation required in section (3) of this rule, the Authority will review the information to determine if it is complete.

(a) If the documentation is not complete or is insufficient the Authority must notify the applicant in writing and the applicant will have 10 calendar days from the date such written notice is mailed by the Authority to provide the additional documentation.

(b) If the applicant does not provide the additional documentation within 10 calendar days or if any responsive documents are incomplete, insufficient or otherwise do not demonstrate compliance with ORS 475B.450 and these rules the application will be declared incomplete.

(9) A person who wishes to register more than one location must submit a separate application, registration fees, and all documentation described in sections (2) and (3) of this rule for each location.

(10) An application that is incomplete is treated by the Authority as if it was never received.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1650
Processing Site Application Review

(1) Applications will be reviewed in the order they are received by the Authority. An application is considered received as of the date and time that payment of fees is authorized by the entity that issued the credit or debit card used to pay the fees.

(2) Once the Authority has determined that an application is complete it will review an application to the extent necessary to determine compliance with ORS 475B.435 and these rules.

(3) The Authority may, in its discretion, prior to acting on an application:

(a) Contact any individual listed on the application and request additional documentation or information;

(b) Inspect the premises of the proposed processing site; or

(c) Verify any information submitted by the applicant.

(4) Prior to making a decision whether to approve or deny an application the Authority must:

(a) Review the criminal background check results for each individual named on the application;

(b) Verify that the applicant is registered as a business with the Office of the Secretary of State; and

(c) Verify that the proposed location of the processing site is not located:

(A) In an area that is zoned for residential use if the processor intends to make extracts; and

(B) Is not in a city or county that has adopted an ordinance under ORS 475B.800 or section 133, chapter 614, Oregon Laws 2015, prohibiting processing sites.

(5) If during the review process the Authority determines that the application or supporting documentation contains intentionally false or misleading information the Authority may declare the application incomplete or deny the application in accordance with OAR 333-008-1670.

(6) The Authority will notify the applicant in writing that the applicant has 60 calendar days from the date of the written notice to submit a Readiness Form, prescribed by the Authority, indicating that the applicant is prepared for an inspection and is in compliance with these rules if:

(a) There is no basis for denial under OAR 333-008-1670;

(b) The proposed processing site is in compliance with ORS 475B.435 and these rules;

(c) Each individual named in the application passes the criminal background check; and

(d) Each individual named as a PRP in the application meets the age requirement.

(7) If the Authority does not receive the Readiness Form in accordance with section (6) of this rule the applicant's application will be declared incomplete, unless an extension has been granted under section (8) of this rule.

(8) An applicant may request one extension of the 60-day deadline in section (6) of this rule if the applicant can demonstrate to the Authority that the deadline cannot be met for reasons outside of the applicant's control, such as but not limited to the applicant's inability to obtain local government building permits.

(a) A request for an extension must be in writing, must be received within 60 calendar days of the notice described in section (6) of this rule, and must explain and provide documentation that shows the applicant cannot, for reasons outside of the applicant's control, meet the 60-day deadline.

(b) A request for an extension tolls the 60-day deadline.

(c) The Authority will review the request and provide, in writing to the applicant, its decision and the reason for the decision.

(d) If an extension is granted the Authority must inform the applicant of the new deadline for submission of the Readiness Form, but in any case an extension may not exceed 60 calendar days.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1670
Denial of Processing Site Application

(1) The Authority must deny an application for the registration of a processing site if:

(a) An application, supporting documentation provided by the applicant, or other information obtained by the Authority shows that the qualifications for a processing site in ORS 475B.435 or these rules have not been met; or

(b) An individual named in an application has been:

(A) Convicted for the manufacture or delivery of a controlled substance in Schedule I or Schedule II within two years from the date the application was received by the Authority; or

(B) Convicted more than once for the manufacture or delivery of a controlled substance in Schedule I or Schedule II; or

(c) The city or county in which the facility is located has prohibited processing sites in accordance with ORS 475B.800 or section 133, chapter 614, Oregon Laws 2015.

(2) The Authority may deny an applicant if it determines that the applicant, the owner of the processing site, a PRP, or an employee of the processing site:

(a) Submitted false or misleading information to the Authority; or

(b) Violated a provision of ORS 475B.400 to 475.525, 475B.555, 475B.605, 475B.615, OAR chapter 333, division 7, these rules or an ordinance adopted pursuant to ORS 475B.500.

(3) If an individual named in an application is not qualified based on age, or the criminal background check, the Authority will permit a change form to be submitted in accordance with OAR 333-008-1720 or 333-008-2030, along with the applicable criminal background check fee. If the individual named in the change form is not qualified the Authority must deny the application in accordance with section (1) of this rule.

(4) If the Authority intends to deny an application for registration it must issue a Notice of Proposed Denial in accordance with ORS 183.411 through 183.470.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1690
Expiration and Renewal of Registration for Processing Site

(1) A processing site's registration expires one year following the date of application approval.

(2) A processing site registrant must submit not more than 90 but at least 30 calendar days before the registration expires:

(a) A renewal application on a form prescribed by the Authority;

(b) Renewal fees;

(c) For each individual named in the renewal application:

(A) A legible copy of the individual's valid government issued photographic identification that includes last name, first name and date of birth;

(B) Information, fingerprints and fees required for a criminal background check in accordance with OAR 333-008-2020; and

(C) An Individual History Form and any information identified in the form that is required to be submitted.

(d) Current proof of business registration with the Secretary of State, including all DBA (doing business as) registrations;

(e) Documentation that shows the applicant has lawful possession of the location of the registered processing site; and

(f) A current scaled floor plan of all enclosed areas at the proposed location that will be used in the business with clear identification of walls, partitions, counters, windows, all areas of ingress and egress, uses of all spaces and all limited access areas.

(3) A registrant who files a completed renewal application, fees, and all the information required in section (2) of this rule with the Authority prior to the expiration date of the registration may continue to operate, even after the registration expiration date, pending a decision on the renewal application by the Authority.

(4) A processing site registrant that does not submit a timely application, fees and all the information required in section (2) of this rule may be subject to the imposition of civil penalties.

(5) If a processing site registrant does not submit the renewal application, fees and all the information required in section (2) of this rule prior to the registration's expiration, the registration is expired and is no longer valid.

(6) Renewals will be processed in accordance with OAR 333-008-1650 to 333-008-1670, as applicable.

(7) A renewal applicant may be required to submit a Readiness Form, as described in OAR 333-008-1650(9) and may be subject to inspection prior to the Authority acting on a renewal application.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1710
PRP Criteria and Responsibilities

(1) A PRP must:

(a) Be 21 years or age or older;

(b) Have legal authority to act on behalf of the registered processing site; and

(c) Be responsible for ensuring the registered processing site complies with applicable laws.

(2) A PRP may not:

(a) Have been convicted in any state for the manufacture or delivery of a controlled substance in Schedule I or Schedule II within two years from the date of application; or

(b) Have been convicted more than once in any state for the manufacture or delivery of a controlled substance in Schedule I or Schedule II.

(3) At least one PRP must be on site at a processing site during Authority inspections or investigations at the time of the inspection or investigation or within one hour of being notified that an inspection or investigation is taking place.

(4) A PRP is accountable for any intentional or unintentional action of a processing site representative, with or without the knowledge of the PRP, who violates ORS 475B.435 to 475B.440 or these rules, and is responsible for any unlawful conduct that occurs on the premises of the processing site or any property outside the registered processing site that is owned by or under the control of the processing site registrant.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1720
Removal, Addition, Change, Designation or Assignment of PRP

(1) If an owner of a registered processing site is adding or changing a PRP or primary PRP, an individual with legal authority to act on behalf of the registered processing site must submit:

(a) A form, prescribed by the Authority;

(b) A legible copy of the individual's valid government issued photographic identification that includes last name, first name and date of birth;

(c) Information and fingerprints required for a criminal background check in accordance with OAR 333-008-2020; and

(d) A criminal background check fee of $35.

(2) A PRP who is designating or assigning the responsibilities of a PRP to another individual must submit the information and fees required in section (1) of this rule. The duties of a primary PRP may not be designated or assigned.

(3) The Authority will review and approve the addition or change of a PRP or primary PRP if the individual meets the requirements in OAR 333-008-1710.

(4) The Authority will review and approve the designation or assignment of the responsibilities of a PRP to another individual if that individual meets the requirements in OAR 333-008-1710. An individual to whom a designation or assignment is made, and who is approved by the Authority, has the same legal obligations as a PRP.

(5) An individual may not act in the capacity of a PRP without approval from the Authority.

(6) If the Authority denies the request to add or change a PRP or primary PRP, or denies the request to designate or assign the responsibilities of a PRP to another individual, the Authority must notify the individual that submitted the request of the denial and the current primary PRP and describe the reason for the denial.

(7) A registered processing site may not process marijuana or receive or transfer any marijuana items without at least one Authority approved PRP and a primary PRP.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1730
Registered Processing Site Premises Restrictions and Requirements

(1) A registered processing site may not be located in an area that is zoned for residential use if the processing site is endorsed to make cannabinoid extracts.

(2) In order to be registered a processing site must operate at a particular location as specified in the application and may not be mobile.

(3) Minors on Premises. A registered processing site may not permit a minor to be present in any limited access area of a registered processing site.

(4) On Premises Consumption.

(a) A registered processing site may not permit the ingestion, inhalation or topical application of a marijuana item anywhere on the premises of the processing site, except as described in subsection (b) of this section.

(b) An employee of a registered processing site who is a patient may consume a marijuana item during his or her work shift on the premises of the registered processing site as necessary for his or her medical condition, if the employee is:

(A) Alone and in a closed room where no processing site marijuana items are present; and

(B) Not visible to the public outside the registered processing site.

(c) For purposes of this section consume does not include smoking, combusting, inhaling, vaporizing, or aerosolizing a marijuana item.

(5) General Public and Visitor Access. The general public is not permitted on the premises of registered processing site, except as permitted by this rule.

(a) In addition to registrant representatives, the following visitors are permitted on the premises of a processing site, including limited access areas, subject to the requirements in section (6) of this rule:

(A) Laboratory personnel, if the laboratory is accredited by the Authority;

(B) A contractor authorized by a registrant representative to be on the premises; or

(C) Individuals authorized to transfer marijuana items to a registered processing site.

(b) A registered processing site may permit up to seven invited guests 21 years of age and older, per week, on the premises of a registered processing site, including limited access areas, subject to the requirements in section (6) of this rule.

(6) Visitor Escort, Log and Badges.

(a) Prior to entering the premises of a registered processing site all visitors permitted by section (5) of this rule must be documented and issued a visitor identification badge from a registrant representative that must remain visible while on the premises. A visitor badge is not required for government officials. All visitors described in section (5) of this rule must be accompanied by a registrant representative at all times.

(b) A processing site registrant must maintain a log of all visitor activity and the log must contain the first and last name and date of birth of every visitor, and the date they visited.

(7) Government Access. Nothing in this rule is intended to prevent or prohibit Authority employees or contractors, or other state or local government officials that have jurisdiction over some aspect of the premises or a registered processing site to be on the premises.

(a) A visitor badge is not required for government officials.

(b) A processing site must log every government official that enters the premises but the processing site may not request that the government official provide a date of birth for the log.

(8) A registered processing site must have:

(a) A designated limited access area or areas where transfers of marijuana items are received; and

(b) A designated area where visitors enter the processing site premises and are checked in.

(9) The areas described in section (8) of this rule must be clearly marked on the floor or plot plan sketch required in OAR 333-008-1650.

(10) Signage. A registered processing site must post:

(a) At every entrance to the processing site a sign that reads: "No On-Site Consumption of Marijuana".

(b) At all areas of ingress to a limited access area signs that reads:

(A) "Restricted Access Area — Authorized Personnel Only".

(B) "No Minors Allowed".

(11) A processing site may not sublet or share with any other business any portion of the processing site premises, except as permitted in OAR 333-008-1790.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1740
Operation of Registered Processing Site

(1) Policies and Procedures. In order to be registered and remain registered a processing site must create and maintain written, detailed standard policies and procedures that include but are not limited to:

(a) Instructions for making each medical cannabinoid product, concentrate or extract.

(b) The ingredients and the amount of each ingredient for each process lot.

(c) The process for making each product.

(d) The number of servings in a process lot.

(e) The intended amount of THC per serving and in a unit of sale of the product.

(f) The process for ensuring that the amount of THC is consistently distributed throughout each process lot.

(g) If processing a cannabinoid concentrate or extract:

(A) Conducting necessary safety checks prior to commencing processing; and

(B) Purging any solvent or other unwanted components from a cannabinoid concentrate or extract.

(h) Procedures for cleaning all equipment, counters and surfaces thoroughly.

(i) Proper handling and storage of any solvent, gas or other chemical used in processing or on the processing site premises in accordance with material safety data sheets and any other applicable laws.

(j) Proper disposal of any waste produced during processing in accordance with all applicable local, state and federal laws, rules and regulations.

(k) Quality control procedures designed to, at a minimum, ensure that the amount of THC is consistently distributed throughout each process lot and that potential product contamination is minimized.

(l) Appropriate use of any necessary safety or sanitary equipment.

(m) Emergency procedures to be followed in case of a fire, chemical spill or other emergency.

(n) Security.

(o) Transfers of marijuana items to and from the processing site.

(p) Testing.

(q) Packaging and labeling if the processor intends to or is packaging and labeling marijuana items after transfer to the processing site.

(r) Employee training.

(s) Compliance with these rules, including but not limited to violations and enforcement.

(t) Roles and responsibilities for employees and PRPs in assisting the Authority during inspections or investigations.

(2) Prohibitions. A registered processing site may not process or transfer a marijuana item:

(a) That by its shape, design or flavor is likely to appeal to minors, including but not limited to:

(A) Products that are modeled after non-cannabis products primarily consumed by and marketed to children; or

(B) Products in the shape of an animal, vehicle, person or character.

(b) That is made by applying cannabinoid concentrates or extracts to commercially available candy or snack food items.

(c) That contains dimethyl sulfoxide (DMSO).

(3) Employees. A registered processing site may employ an individual between the ages of 18 and 20 if the individual is a patient. Otherwise, processing site employees must be 21 years of age or older.

(4) Standardized Scales. In order to obtain a registration and to retain registration a processing site registrant must own, maintain on the premises and use a weighing device that is licensed by the Oregon Department of Agriculture. Licensed weighing devices must be used by a processing site whenever marijuana items are:

(a) Transferred to or from the processing site and the transfer is by weight;

(b) Packaged for transfer by weight; or

(c) Weighed for purposes of documenting information required in OAR 333-008-1760, 333-008-1770, 333-008-1820, and 333-008-1830.

(5) Inventory Tracking and Point of Sale System: A registered processing site must have an integrated inventory tracking and point of sale system that can and does, at a minimum:

(a) Produce bar codes or similar unique identification numbers for each lot of usable marijuana transferred to a registered processing site and for each lot of a medical cannabinoid product, concentrate or extract transferred to a registered dispensary;

(b) Capture all information required to be documented in OAR 333-008-1760 and 333-008-1770;

(c) Generate inventory, transaction, transport and transfer reports requested by the Authority viewable in PDF format; and

(d) Produce all the information required to be submitted to the Authority pursuant to OAR 333-0080-1830.

(6) Online Verification of Registration Status. A registered processing site must verify an individual's or processing site's registration status with the Authority when receiving a transfer of a marijuana item if the Authority has available an online system for such verification.

(7) Transfers from and to patients or designated primary caregivers.

(a) A registered marijuana processing site may transfer a medical cannabinoid product, concentrate or extract to a patient, or a patient's designated primary caregiver if the patient or the patient's designated primary caregiver provides the marijuana processing site with the marijuana to be processed into the medical cannabinoid product, concentrate or extract and the marijuana processing site receives no compensation for the transfer of the marijuana.

(b) A registered processing site must document each transfer of marijuana by a patient or the patient's designated primary caregiver to the processing site in accordance with OAR 333-008-1760 and 333-008-1770.

(c) A registered processing site must document each transfer of a cannabinoid product, concentrate or extract to a patient or the patient's designated primary caregiver in accordance with OAR 333-008-1760 and 333-008-1770.

(d) A registered processing site may be compensated by the patient or the patient's designated primary caregiver for all costs associated with the processing of marijuana for the patient.

(8) Inventory On-Site. Marijuana items must be kept on-site at the registered processing site. The Authority may take enforcement action against a registered processing site if during an inspection a processing site cannot account for its inventory or if the amount of usable marijuana at the processing site is not within five percent of the documented inventory.

(9) Testing.

(a) Prior to October 1, 2016, a registered processing site must comply with the applicable sampling and testing requirements in OAR 333-008-1190 or if using an accredited laboratory, comply with OAR 333-007-0300 to 333-007-0490.

(b) On and after October 1, 2016, a registered processing site must comply with OAR 333-007-0300 to 333-007-0490 and may not:

(A) Accept a transfer of a marijuana item that has not been tested in accordance with OAR 333-007-0300 to 333-007-0490.

(B) Transfer a medical cannabinoid product, concentrate or extract that has not been tested in accordance with OAR 333-007-0300 to 333-007-0490.

(10) Packaging and Labeling.

(a) Prior to October 1, 2016, a registered processing site must comply with the labeling and packaging rules in OAR 333-008-1220 and 333-008-1225, 333-007-0010 to 333-007-0100 or 845-025-7000 to 845-025-7020 and 845-025-7060.

(b) On and after October 1, 2016, a registered processing site must comply with the labeling requirements in OAR 333-007-0010 to 333-007-0100, and the packaging requirements in OAR 845-025-7000 to 845-025-7020 and 845-025-7060.

(11) Industrial Hemp Products. A processing site may only accept the transfer of and may only transfer a product that contains THC or CBD that is derived from marijuana.

(12) Sampling. A registered processing site may provide a sample of a medical cannabinoid product, concentrate or extract to a dispensary for the purpose of the dispensary determining whether to purchase the product, concentrate or extract but the product, concentrate or extract may not be consumed on the processing site. Any sample provided to a dispensary must be recorded in the database.

(13) For purposes of this rule:

(a) "Lot of usable marijuana" means a quantity of usable marijuana transferred to a registered processing site from the same harvest lot as that term is defined in OAR 333-007-0020; and

(b) "Lot of medical cannabinoid products, concentrates or extracts" means a quantity of a medical cannabinoid product, concentrate or extract transferred to a registered dispensary at one time and that is from the same process lot as that term is defined in OAR 333-007-0020.

Stat. Auth.: ORS 475B.435, 475B.440
Stats. Implemented: ORS 475B.435, 475B.440
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1760
Transfers to a Registered Processing Site

(1) Transfers of Marijuana by a Patient or Designated Primary Caregiver to Process for a Patient. A patient or designated primary caregiver may transfer marijuana to a registered processing site for no compensation for the purpose of the registered processing site processing the marijuana into a cannabinoid product, concentrate or extract.

(a) If a designated primary caregiver is transferring the marijuana, a registered processing site may only accept a transfer of marijuana under this section if the caregiver provides the original or a copy of a valid Authorization to Transfer form prescribed by the Authority.

(b) In order to be valid an Authorization to Transfer form must include at least:

(A) The patient's name, OMMP card number, OMMP receipt number if applicable and expiration date and contact information;

(B) The name and contact information of the individual who is authorized to transfer the usable marijuana to the registered processing site and that individual's OMMP card number and expiration date;

(C) The name and address of the registered processing site that is authorized to receive the usable marijuana; and

(D) The date the authorization expires, if earlier than the expiration date of the patient's OMMP card or receipt.

(2) Transfer of Usable Marijuana. A patient, caregiver, or PRMG may transfer usable marijuana to a registered processing site, subject to the requirements in this rule.

(a) A registered processing site may only accept a transfer of usable marijuana if the individual transferring the usable marijuana provides the original or a copy of a valid:

(A) Authorization to Transfer form prescribed by the Authority; or

(B) Personal agreement as that is defined in OAR 333-008-0010.

(b) Authorization to Transfer Forms. In order to be valid an Authorization to Transfer form must include at least:

(A) The patient's name, OMMP card number and expiration date and contact information;

(B) The name and contact information of the individual who is authorized to transfer the usable marijuana to the registered processing site and that individual's OMMP card number and expiration date;

(C) The name and address of the registered processing site that is authorized to receive the usable marijuana; and

(D) The date the authorization expires, if earlier than the expiration date of the patient's OMMP card.

(c) Personal Agreements. In order to be valid a personal agreement must include at least:

(A) The patient's name, OMMP card number and expiration date and contact information;

(B) The name and contact information of the PRMG to whom the patient's property rights have been assigned and the producer's OMMP card number and expiration date;

(C) The portion of the patient's rights to possess usable marijuana that is being assigned to the producer.

(3) Transfer of medical cannabinoid products, concentrates or extracts. A registered processing site may only accept a transfer of a medical cannabinoid product, concentrate or extract from another registered medical marijuana processing site.

(4) A registered processing site may only accept a transfer of a medical cannabinoid product, concentrate or extract from a registered processing site that provides a Processing Site Authorization to Transfer form, prescribed by the Authority. In addition the registered processing site must obtain a copy of the photo identification of the individual transferring the product, concentrate or extract as required in section (5)(b)(B) of this rule.

(5) Transfer Records. At the time marijuana, usable marijuana or a medical cannabinoid product, concentrate or extract is transferred to a registered processing site a processing site representative must:

(a) Document, as applicable:

(A) The weight in metric units of all usable marijuana received by the processing site;

(B) The amount of a medical cannabinoid product, concentrate or extract received by the processing site, including, as applicable, the weight in metric units, or the number of units;

(C) The name of the usable marijuana or medical cannabinoid product, concentrate or extract;

(D) The date the usable marijuana or medical cannabinoid product, concentrate or extract was received; and

(E) The amount of reimbursement paid by the registered processing site.

(b) Obtain and maintain a copy of, as applicable:

(A) Documents required in section (1) of this rule including the date it was received;

(B) The photo identification of the individual transferring the usable marijuana or medical cannabinoid product, concentrate or extract to the registered processing site, if such a copy is not already on file;

(C) The OMMP card of the individual transferring usable marijuana;

(D) The medical marijuana processing site registration; and

(E) Test results for marijuana items transferred to the processing site unless the processing site plans to arrange for the testing of the marijuana item.

(6) Prior to October 1, 2016, if a registered processing site accepts the transfer of usable marijuana or a medical cannabinoid product, concentrate or extract that has not been tested in accordance with OAR 333-008-1190 or OAR 333-007-0300 to 333-007-0490 the processing site must segregate that item in accordance with OAR 333-008-1190(7).

(7) Once samples of the usable marijuana or a medical cannabinoid product, concentrate or extract have been taken for the purpose of testing the item must be stored and secured in a manner that prevents the product from being tampered with or transferred prior to test results being reported.

(8) Nothing in these rules requires a registered processing site to accept a transfer of a marijuana item.

(9) All documentation required in this rule must be maintained electronically in an integrated inventory tracking and point of sale system.

Stat. Auth.: ORS 475B.435, 475B.440
Stats. Implemented: ORS 475B.435, 475B.440
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1770
Transfers From a Registered Processing Site

(1) A registered processing site must, in addition to the completing a Processing Site Authorization to Transfer form, prescribed by the Authority, document the following for transfers to a registered dispensary or registered processing site:

(a) The name, address, and registration number of the dispensary or processing site to which a medical cannabinoid product, concentrate or extract was transferred;

(b) The amount of medical cannabinoid product, concentrate, or extract transferred;

(c) The name of the medical cannabinoid product, concentrate, or extract transferred;

(d) The date of the transfer; and

(e) The amount of money paid by the registered dispensary or processing site for the transfer.

(2) A registered processing site must document the following for the transfer of a medical cannabinoid product, concentrate or extract to a patient or designated primary caregiver pursuant to ORS 475B.443(1)(b) and (c):

(a) The name and registration number or OMMP receipt number of the patient or designated primary caregiver to which a medical cannabinoid product, concentrate or extract was transferred;

(b) If the medical cannabinoid product, concentrate or extract was transferred to a designated primary caregiver, the patient's name and registration number for whom the caregiver was receiving the transfer;

(c) The amount of medical cannabinoid product, concentrate, or extract transferred;

(d) The name of the medical cannabinoid product, concentrate, or extract transferred;

(e) The date of the transfer; and

(f) The amount of money paid by the patient or designated primary caregiver for the transfer.

(3) All documentation required in this rule must be maintained electronically in an integrated inventory tracking and point of sale system.

Stat. Auth.: ORS 475B.435
Stats. Implemented: ORS 475B.435
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1780
General Processing Site Health and Safety Requirements

(1) A processing site must:

(a) Use equipment, counters and surfaces for processing that are food-grade and do not react adversely with any solvent being used.

(b) Have counters and surface areas that are constructed in a manner that reduce the potential for development of microbials, molds and fungi and that can be easily cleaned.

(c) Maintain the processing site in a manner that is free from conditions which may result in contamination and that is suitable to facilitate safe and sanitary operations for product preparation purposes.

(2) A processing site may not treat or otherwise adulterate a medical cannabinoid product, concentrate or extract with any additives that would increase potency, toxicity, or addictive potential, or that would create an unsafe combination with other psychoactive substances. Prohibited additives include but are not limited to nicotine, alcohol, caffeine, or chemicals that increase carcinogenicity.

Stat. Auth.: ORS 475B.435, 475B.440
Stats. Implemented: ORS 475B.435, 475B.440
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1790
Cannabinoid Edible Processor Requirements

(1) A processing site endorsed to make cannabinoid edibles may only process in a food establishment licensed by the Oregon Department of Agriculture (ODA) and must comply with the applicable provisions of OAR chapter 603, division 21, division 24, division 25, with the exception of OAR 603-025-0020(17), and division 28.

(2) A processing site endorsed to make cannabinoid edibles may not:

(a) Engage in processing in a location that is operating as a restaurant, seasonal temporary restaurant, intermittent temporary restaurant, limited service restaurant or single-event temporary restaurant licensed under ORS chapter 624;

(b) Share a food establishment with a person not registered with the Authority as a cannabinoid edible processor;

(c) Process cannabinoid edibles and food in the same food establishment; or

(d) Use a cannabinoid concentrate or extract in a cannabinoid edible unless that concentrate or extract was processed in a food establishment licensed by ODA under OAR chapter 603, division 21, division 24, division 25, with the exception of OAR 603-025-0020(17), and division 28.

(3) A processing site endorsed to make cannabinoid edibles may share a food establishment with another Authority registered cannabinoid edible processor if:

(a) The schedule, with specific hours and days that each processor will use the food establishment, is prominently posted at the entrance to the food service establishment.

(b) Each registrant designates a separate area to secure, in accordance with OAR 333-008-2080 any marijuana, medical cannabinoid products, concentrates or extracts that a registrant stores at the food establishment. If a cannabinoid edible processor does not store marijuana, medical cannabinoid products, concentrates or extracts at the food establishment those items must be stored on a registered processing site under the processor's control.

(4) A food establishment used by a processing site endorsed to make cannabinoid edibles is considered a registered processing site and must meet the security and other premises requirements in these rules.

(5) A processing site endorsed to make cannabinoid edibles is strictly liable for any violation found at a shared food establishment during that processor's scheduled time, as reflected on the posted schedule or within that processor's designated area in the food establishment.

(6) If the Authority cannot determine by viewing the schedule or video surveillance footage who was responsible for the violation, each processor at the shared food establishment is individually and jointly liable for any documented violations.

(7) A processing site must make cannabinoid edibles in a manner that results in the THC being distributed consistently throughout the edible.

Stat. Auth.: ORS 475B.435 & 475B.440
Stats. Implemented: ORS 475B.435 & 475B.440
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1800
Cannabinoid Concentrate and Extract Processor Requirements

(1) Cannabinoid Concentrates or Extracts. A processing site endorsed to make cannabinoid concentrates or extracts:

(a) May not use Class I solvents as those are classified in the Federal Drug Administration Guidance, Table I, published in the Federal Register on December 24, 1997 (62 FR 67377).

(b) Must:

(A) Only use a hydrocarbon-based solvent that is at least 99 percent purity.

(B) Only use a non-hydrocarbon-based solvent that is food-grade.

(C) Work in an environment with proper ventilation, controlling all sources of ignition where a flammable atmosphere is or may be present.

(D) Use only potable water and ice made from potable water in processing.

(E) If making a concentrate or extract that will be used in a cannabinoid edible, be endorsed as a cannabinoid edible processor.

(2) Cannabinoid Extracts. A processing site endorsed to make cannabinoid extracts:

(a) May not use pressurized canned flammable fuel, including but not limited to butane and other fuels intended for use in camp stoves, handheld torch devices, refillable cigarette lighters and similar consumer products

(b) Must:

(A) Process in a:

(i) Fully enclosed room clearly designated on the current diagram of the registered premises.

(ii) Room and with equipment, including all electrical installations, that meet the requirements of the Oregon Structural Specialty Code, related Oregon Specialty Codes and the Oregon Fire Code..

(B) Use a commercially manufactured professional grade closed loop extraction system designed to recover the solvents and built to recognized and generally accepted good engineering standards, such as those of:

(i) American National Standards Institute (ANSI);

(ii) Underwriters Laboratories (UL); or

(iii) The American Society for Testing and Materials (ASTM).

(C) If using carbon dioxide in processing, use a professional grade closed loop carbon dioxide gas extraction system where every vessel is rated to a minimum of 600 pounds per square inch.

(D) For extraction system engineering services, including but not limited to consultation on and design of extraction systems or components of extraction systems, use the services of a professional engineer registered with the Oregon State Board of Examiners for Engineering and Land Surveying, unless an exemption under ORS 672.060 applies;

(E) Have an emergency eye-wash station in any room in which cannabinoid extract is being processed.

(F) Have all applicable material safety data sheets readily available to personnel working for the processor.

(3) Cannabinoid Concentrates. A processing site endorsed to make cannabinoid concentrates:

(a) May not:

(A) Use denatured alcohol.

(B) If using carbon dioxide, apply high heat or pressure.

(b) Must only use or store dry ice in a well ventilated room to prevent against the accumulation of dangerous levels of carbon dioxide.

(c) May use:

(A) A mechanical extraction process;

(B) A chemical extraction process using a nonhydrocarbon-based or other solvent, such as water, vegetable glycerin, vegetable oils, animal fats, isopropyl alcohol or ethanol; or

(C) A chemical extraction process using the hydrocarbon-based solvent carbon dioxide, provided that the process does not involve the use heat over 180 degrees or pressure.

Stat. Auth.: ORS 475B.435, 475B.440
Stats. Implemented: ORS 475B.435, 475B.440
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16
28-16

333-008-1810
Cannabinoid Topical Processor

(1) A processing site endorsed to make cannabinoid topicals, tinctures, capsules, suppositories or transdermal patches may not engage in processing in a location that is operating as a restaurant, seasonal temporary restaurant, intermittent temporary restaurant, limited service restaurant or single-event temporary restaurant licensed under ORS chapter 624.

(2) A registered processing site making cannabinoid tinctures may only process in a food establishment licensed by the Oregon Department of

Agriculture (ODA) and must comply with the applicable provisions of OAR chapter 603, division 21, division 24, division 25, with the exception of OAR 603-025-0020(17), and division 28.

Stat. Auth.: ORS 475B.435, 475B.440
Stats. Implemented: ORS 475B.435, 475B.440
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-1830
Registered Marijuana Processing Site Required Reporting to the Authority

(1) The individual or individuals responsible for a marijuana processing site shall maintain documentation of each transfer of usable marijuana, medical cannabinoid products, cannabinoid concentrates and cannabinoid extracts and on and after June 1, 2016, must submit to the Authority electronically, by the 10th of each month, the following information:

(a) The amount of usable marijuana transferred to the marijuana processing site during the previous month.

(b) The amount and type of a medical cannabinoid concentrate or extract transferred by another registered processing site during the previous month. For purposes of this section "type" means:

(A) Cannabinoid concentrate in solid form; and

(B) Cannabinoid concentrate in liquid form.

(c) The amount and type of medical cannabinoid products transferred by the marijuana processing site to a dispensary. For purposes of this section "type" means:

(A) Cannabinoid edibles;

(B) Cannabinoid topicals;

(C) Cannabinoid tinctures;

(D) Cannabinoid capsules;

(E) Cannabinoid suppositories;

(F) Cannabinoid transdermal patches; and

(G) Cannabinoid product other than products listed in paragraphs (A) to (F) of this subsection.

(d) The amount and type of cannabinoid concentrates transferred by the marijuana processing site during the previous month. For purposes of this section "type" means:

(A) Cannabinoid concentrate in solid form; and

(B) Cannabinoid concentrate in liquid form.

(e) The amount and type of cannabinoid extracts transferred by the marijuana processing site during the previous month. For purposes of this section "type" means:

(A) Cannabinoid extract in solid form; and

(B) Cannabinoid extract in liquid form.

(f) The amount and type of medical cannabinoid products transferred by the marijuana processing site to a patient or the patient's designated primary caregiver during the previous month. For purposes of this section "type" means:

(A) Cannabinoid edibles;

(B) Cannabinoid topicals;

(C) Cannabinoid tinctures;

(D) Cannabinoid capsules;

(E) Cannabinoid suppositories;

(F) Cannabinoid transdermal patches; and

(G) Cannabinoid product other than products listed in paragraphs (A) to (F) of this subsection.

(g) The amount and type of cannabinoid concentrates or extracts transferred by the marijuana processing site to a patient or the patient's designated primary caregiver during the previous month. For purposes of this section "type" means;

(A) Cannabinoid concentrate or extract in liquid form; and

(B) Cannabinoid concentrate or extract in solid form.

(2) Information submitted to the Authority under this rule must:

(a) List each type of marijuana item separately;

(b) Provide the total aggregate amount of a type of marijuana item transferred to a processing site by a patient, designated primary caregiver, PRMG or other registered processing site during the previous month; and

(c) Provide the total aggregate amount of a type of marijuana item transferred from a processing site to a registered dispensary, patient, designated primary caregiver, or other registered processing site during the previous month.

(3) In addition to submitting the information as required by section (1) of this rule, a person responsible for a processing site must keep a record of the information described in section (1) of this rule for two years after the date on which the person submits the information to the Authority.

Stat. Auth.: ORS 475B.438
Stats. Implemented: ORS 475B.438
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-2030
Notification of Changes

(1) A registrant must notify the Authority within 10 calendar days of any of the following:

(a) The conviction for the manufacture or delivery of a controlled substance in Schedule I or Schedule II of any individual named in the application;

(b) A change in any contact information for anyone listed in an application or subsequently identified as an owner, an individual with a financial interest, a PRD or a PRP;

(c) A decision to remove a PRD, PRP, primary PRD or primary PRP;

(d) A decision to permanently close the dispensary or processing site at that location;

(e) For a dispensary, the location of a public or private elementary or secondary school within 1,000 feet of the dispensary; and

(f) The suspected theft of marijuana items.

(2) The notification required in section (1) of this rule must include a description of what has changed or the event and any documentation necessary for the Authority to determine whether the dispensary or processing site or dispensary or processing site registrant is still in compliance with ORS 475B.435, 475B.450 and these rules including but not limited to, as applicable:

(a) A copy of the criminal judgment or order;

(b) The location of the school that has been identified as being within 1,000 feet of the dispensary; or

(c) A copy of the police report documenting that the suspected theft of marijuana items was reported to law enforcement, if it was reported.

(3) Changes in Ownership, Financial Interest or Business Structure. A registrant that proposes to change its corporate structure, ownership structure or change who has a financial interest in the business must submit a form prescribed by the Authority, any information identified in the form to be submitted, and criminal background check fees, if applicable, to the Authority, prior to making such a change.

(a) The Authority must review the form and other information submitted and will approve the change if the change would not result in an initial or renewal application denial under OAR 333-008-1060 or 333-008-1670, or serve as the basis of a registration suspension or revocation.

(b) If the Authority denies the change but the registrant proceeds with the change the registrant must surrender the registration or the Authority will propose to suspend or revoke the registration.

(4) Failure of a registrant to notify the Authority in accordance with this rule may result in the imposition of civil penalties or the suspension or revocation of a dispensary or processing site's registration.

Stat. Auth.: ORS 475B.435, 475B.450, 475B.525
Stats. Implemented: ORS 475B.435, 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-2080
Security Requirements

In order to be registered and remain registered a registrant must:

(1) Have an installed and fully operational security alarm system, installed by an alarm installation company, activated at all times when the premises is closed for business on all:

(a) Entry or exit points to and from the premises; and

(b) Perimeter windows, if applicable.

(2) Have a security alarm system that:

(a) Detects movement inside the premises;

(b) Is programmed to notify a security company that will notify a registrant representative or his or her designee in the event of a breach; and

(c) Has at least two operational "panic buttons" located inside the premises that are linked with the alarm system that notifies a security company.

(3) Have commercial grade, non-residential door locks installed on every external door of a registered premises where marijuana items are present.

(4) During all hours when the registrant is not operating:

(a) Securely lock all entrances to and exits from the registered premises and ensure any keys or key codes to the enclosed area remain in the possession of the registrant or registrant representative;

(b) Have a safe or vault as those terms are defined in OAR 333-008-0010 for the purpose of securing all marijuana items as required by these rules.

(5) Have a password protected network infrastructure.

(6) Have an electronic back-up system for all electronic records.

(7) Keep all video recordings and archived required records not stored electronically in a locked storage area. Current records may be kept in a

locked cupboard or desk outside the locked storage area during hours when the registered business is open.

Stat. Auth.: ORS 475B.435, 475B.450, 475B.525
Stats. Implemented: ORS 475B.435, 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-2090
Video Surveillance Equipment

In order to be registered and remain registered a registrant must:

(1) Have an installed and fully operational video surveillance recording system with video surveillance equipment that at a minimum:

(a) Consists of:

(A) Digital or network video recorders;

(B) Cameras capable of meeting the requirements of OAR 333-008-2110 and this rule;

(C) Video monitors;

(D) Digital archiving devices;

(E) A minimum of one monitor on premises capable of viewing video; and

(F) A color printer capable of producing still photos.

(b) Is equipped with a failure notification system that immediately notifies a registrant representative of any surveillance interruption or failure that is longer than five minutes; and

(c) Has sufficient battery backup to support a minimum of one hour of recording time in the event of a power outage.

(2) Have a video surveillance system capable of recording all predetermined surveillance areas in any lighting conditions.

(3) Have, in limited access and point of sale areas, cameras that have minimum resolution of 1280 x 720 pixels (px) and record at 10 fps (frames per second).

(4) Have, in exterior perimeter and non-limited access areas (except for restrooms) cameras that have a minimum resolution of 1280 x 720 px and record at least 5 fps, except where coverage overlaps any limited access areas such as entrances or exits and in those overlap areas cameras must record at 10 fps.

Stat. Auth.: ORS 475B.435, 475B.450, 475B.525
Stats. Implemented: ORS 475B.435, 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-2100
Required Camera Coverage and Camera Placement

In order to be registered and remain registered a registrant must:

(1) Have security camera coverage for:

(a) All secure and limited access areas;

(b) All areas where marijuana items will be and are transferred to or from a registered premises;

(c) All areas where the general public is permitted (except for restrooms);

(d) All points of entry to and exit from limited access areas and areas where marijuana items will be and are transferred to or from a registered premises; and

(e) All points of entry to and exit from the premises.

(2) Have cameras that are positioned so that they capture clear and certain images of any individual and activity occurring:

(a) Within 15 feet both inside and outside of all points of entry to and exit from the premises;

(b) Anywhere within a secure or limited access area on the premises; and

(c) Anywhere within an area where marijuana items will be and are transferred to or from a registered premises.

Stat. Auth.: ORS 475B.435, 475B.450, 475B.525
Stats. Implemented: ORS 475B.435, 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-2110
Video Recording Requirements

(1) In order to be registered and remain registered a registrant must:

(a) Have cameras that are installed, operational, and continuously record 24 hours a day in all areas where marijuana items will be or are on the premises, including areas where the general public is permitted (except restrooms).

(b) Use cameras that record at a minimum resolution of 1280 x 720 px;

(c) Have an installed and operational surveillance system that:

(A) Can produce a color still photograph from any camera image; and

(B) Embeds the date and time on all surveillance recordings without significantly obscuring the picture;

(2) A registrant must:

(a) Keep all surveillance recordings a minimum of 45 calendar days and in a format that can be easily accessed for viewing;

(b) Archive video recordings in a format that ensures authentication of the recording as a legitimately-captured video and guarantees that no alterations of the recorded image has taken place;

(c) Provide video surveillance records and recordings immediately upon request to the Authority for the purpose of ensuring compliance with ORS 475B.450 and these rules;

(d) Keep surveillance recordings for periods exceeding 45 calendar days upon request of the Authority; and

(e) Immediately notify the Authority of any equipment failure or system outage lasting 30 minutes or more.

Stat. Auth.: ORS 475B.435, 475B.450, 475B.525
Stats. Implemented: ORS 475B.435, 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-2180
Violations

(1) It is a violation for an applicant for a registration, registrant or registrant representative to:

(a) Fail to cooperate with an inspection;

(b) Submit false or misleading information to the Authority;

(c) If the registrant is a dispensary, transfer a marijuana item to an individual who is not a patient or a designated primary caregiver;

(d) If the registrant is a processing site, transfer a medical cannabinoid product, concentrate or extract to anyone who is not a dispensary representative or a patient;

(e) Accept the transfer of a marijuana item from an individual who is not registered with the Authority;

(f) Accept the transfer of a marijuana item that was produced or processed in another state;

(g) Possess a mature marijuana plant;

(h) Fail to submit a plan of correction in accordance with OAR 333-008-2190;

(i) Fail to comply with an emergency suspension order or final order of the Authority, including failing to pay a civil penalty;

(j) Fail to comply with ORS 475B.435 to 475B.443, 475B.450 to 475B.453, 475B.555, 475B.605, 475B.615, these rules, or OAR chapter 333, division 7; or

(k) Alter or falsify a laboratory test report or result.

(l) Alter or falsify a receipt issued under OAR 333-008-0023 or 333-008-0040

(2) It is a violation of ORS 475B.450 and these rules to operate a dispensary without being registered by the Authority.

(3) It is a violation of ORS 475B.435 and these rules to operate a processing site without being registered by the Authority unless an exemption applies.

Stat. Auth.: ORS 475B.435, 475B.450 & 475B.525
Stats. Implemented: ORS 475B.435 & 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-008-2190
Enforcement

(1)(a) Informal Enforcement. If, during an inspection the Authority documents violations of ORS 475B.435 to 475B.443, 475B.450 to 475B.453, 475B.555, 475B.605, 475B.615, any of these rules or OAR chapter 333, division 7, the Authority may issue a written Notice of Violation to a registrant that cites the laws alleged to have been violated and the facts supporting the allegations.

(b) A registrant must submit to the Authority a signed plan of correction within 10 business days from the date the Notice of Violation was mailed by the Authority. A signed plan of correction will not be used by the Authority as an admission of the violations alleged in the Notice.

(c) A registrant must correct all deficiencies within 10 business days from the date of the Notice, unless an extension of time is requested from the Authority. A request for such an extension shall be submitted in writing and must accompany the plan of correction.

(d) The Authority must determine if a written plan of correction is acceptable. If the plan of correction is not acceptable to the Authority it must notify the registrant in writing and request that the plan of correction be modified and resubmitted no later than 10 business days from the date the letter of non-acceptance was mailed.

(e) If the registrant does not come into compliance by the date of correction reflected on the plan of correction, the Authority may propose to suspend or revoke the registrant's registration or impose civil penalties.

(f) The Authority may conduct an inspection at any time to determine whether a registrant has corrected the deficiencies in a Notice of Violation.

(2) Formal Enforcement. If, during an inspection or based on other information the Authority determines that a registrant is in violation of ORS 475B.435 to 475B.443, 475B.450 to 475B.453, 475B.555, 475B.605, 475B.615, any of these rules or OAR chapter 333, division 7 the Authority may issue:

(a) A Notice of Proposed Suspension or Revocation in accordance with ORS 183.411 through 183.470.

(b) A Notice of Imposition of Civil Penalties in accordance with OAR 333-008-2200.

(c) An Order of Emergency Suspension pursuant to ORS 183.430.

(3) The Authority must determine whether to use the informal or formal enforcement process based on the nature of the alleged violations, whether there are mitigating or aggravating factors, and whether the registrant has a history of violations.

(4) The Authority must issue a Notice of Proposed Revocation if the registrant no longer meets the criteria in ORS 475B.450(3)(a) to (d) or ORS 475B.435(3)(a) or (b).

(5) The Authority may issue civil penalties or maintain a civil action against an establishment providing the services of a processing site or dispensary but is not registered in accordance with ORS 475B.450, ORS 475B.435 and these rules.

(6) The Authority may revoke the registration of a registrant for failure to comply with an ordinance adopted by a city or county pursuant to ORS 475B.500, if the city or county:

(a) Has provided the registrant with due process substantially similar to the due process provided to a registration holder under the Administrative Procedures Act, ORS 183.413 to 183.470; and

(b) Provides the Authority with a final order that is substantially similar to the requirements for a final order under ORS 183.470 that establishes the registrant is in violation of the local ordinance.

(7) The Authority must post a final order revoking the registration of a registrant on the Authority's website.

(8) To the extent permitted by law, if the Authority discovers violations that may constitute criminal conduct or conduct that is in violation of laws within the jurisdiction of other state or local governmental entities, the Authority may refer the matter to the applicable agency.

(9) If the registration of a registrant is revoked the owner or an authorized representative of the owner must:

(a) Make arrangements to return the marijuana items still possessed at the location to the person who transferred the marijuana item, document the return, and provide this information in writing within one business day of the transfer, to the Authority; or

(b) Dispose of the marijuana items in a manner specified by the Authority.

(10) The Authority is not required to accept the surrender of a registration and may proceed with an enforcement action even if a registrant has surrendered the registration.

(11) Notwithstanding OAR 333-008-3000 if the Authority suspends or revokes a registration or otherwise takes disciplinary action against the registrant the Authority must provide that information to a law enforcement agency.

(12) The Authority may possess, seize or dispose of marijuana, usable marijuana, medical cannabinoid products, cannabinoid concentrates and cannabinoid extracts as is necessary for the Authority to ensure compliance with and enforce the provisions of ORS 475B.435 to 475B.443, 475B.450 to 475B.453, 475B.555, 475B.605, 475B.615, any of these rules or OAR chapter 333, division 7.

Stat. Auth.: ORS 431A.010, 475B.435, 475B.450 & 475B.525
Stats. Implemented: ORS 475B.435 & 475B.450
Hist.: PH 9-2016, f. 2-26-16, cert. ef. 3-1-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-064-0100
Marijuana Item Sampling Procedures and Testing

(1) For purposes of this rule the definitions in OAR 333-007-0310 apply unless the context indicates otherwise.

(2) Sampling.

(a) A laboratory must prepare marijuana item sampling policies and procedures that contain all of the information necessary for collecting and transporting samples from a marijuana item in a manner that does not endanger the integrity of the sample for any analysis required by this rule. These policies and procedures must be appropriate to the matrix being sampled.

(b) Sampling policies and procedures must be accredited by ORELAP prior to any marijuana samples being taken. The policies and procedures must be consistent with the following ORELAP sampling protocols approved by the accrediting body, incorporated by reference:

(A) Usable Marijuana: ORELAP-SOP-001 Rev 2.0;

(B) Concentrates and Extract: ORELAP-SOP-002 Rev 2.0; and

(C) Cannabis Products: ORELAP-SOP-003 Rev 2.0. [Sampling protocols may be found on the ORELAP and Cannabis Testing webpage, public.health.oregon.gov/LaboratoryServices/EnvironmentalLaboratoryAccreditation/Pages/cannabis-info.aspx]

(c) Care should be taken by laboratory personnel while sampling to avoid contamination of the non-sampled material. Sample containers must be free of analytes of interest and appropriate for the analyses requested.

(d) A sufficient sample size must be taken for analysis of all requested tests and the quality control performed by the testing laboratory for these tests.

(e) A laboratory must comply with any recording requirements for samples and subsamples in the accredited policies and procedures and at a minimum:

(A) Record the location of each sample and subsample taken.

(B) Assign a field identification number for each sample, subsample and field duplicate that have an unequivocal link to the laboratory analysis identification.

(C) Assign a unique identification number for the test batch in accordance with OAR 333-007-0370 and TNI EL standard requirements.

(D) Have a documented system for uniquely identifying the samples to be tested to ensure there can be no confusion regarding the identity of such samples at any time. This system must include identification for all samples, subsamples, preservations, sample containers, tests, and subsequent extracts or digestates.

(E) Place the laboratory identification code as a durable mark on each sample container.

(F) Enter a unique identification number into the laboratory records. This number must be the link that associates the sample with related laboratory activities such as sample preparation. In cases where the sample collector and analyst are the same individual, or the laboratory pre-assigns numbers to sample containers, the unique identification number may be the same as the field identification code.

(f) Combining subsamples.

(A) Subsamples collected from the same batch must be combined into a single sample by a laboratory prior to testing unless the batch is undergoing process validation or has not yet gone through process validation.

(B) Subsamples and samples collected from different batches may not be combined.

(C) Field duplicates may not be combined with the primary samples.

(3) THC and CBD testing validity. When testing a sample for THC and CBD a laboratory must comply with additional method validation as follows:

(a) Run a laboratory control standard in accordance with TNI standards requirements within acceptance criteria of 70 percent to 130 percent recovery.

(b) Analyze field duplicates of samples within precision control limits of plus or minus 20 percent RPD, if field duplicates are required.

(4) Calculating total THC and total CBD.

(a) Total THC must be calculated as follows, where M is the mass or mass fraction of delta-9 THC or delta-9 THCA:

M total delta-9 THC = M delta-9 THC + 0.877 x M delta-9 THCA.

(b) Total CBD must be calculated as follows, where M is the mass or mass fraction of CBD and CBDA: M total CBD = M CBD + 0.877 x M CBDA.

(c) Each test report must include the total THC and total CBD.

(5) Report total THC and total CBD as Dry Weight. A laboratory must report total THC and Total CBD content by dry weight calculated as follows:

P total THC(dry) = P total THC(wet) / [1-(P moisture/100)]

P total CBD(dry) = P total CBD(wet) / [1-(P moisture/100)]

(6) Calculating RPD and RSD.

(a) A laboratory must use the following calculation for determining RPD: $RPD = (sample\ result - duplicate\ result)(sample\ result + duplicate\ result 2$

(b) A laboratory must use the following calculation for determining RSD: $\%\ RSD = sx \times 100\%\ s = i = 0n(xi - x)2(n - 1)$

(c) For purposes of this section:

(A) S = standard deviation.

(B) n = total number of values.

(C) xi = each individual value used to calculate mean.

(D) x = mean of n values.

(d) For calculating both RPD and RSD if any results are less than the LOQ the absolute value of the LOQ is used in the equation.

(7) Tentative Identification of Compounds (TIC).

(a) If a laboratory is using a gas chromatography mass spectrometry instrument for analysis when testing cannabinoid concentrates or extracts for solvents and determines that a sample may contain compounds that are not included in the list of analytes the laboratory is testing for the laboratory must attempt to achieve tentative identification.

(b) Tentative identification is achieved by searching NIST 2014 or an equivalent database (>250,000 compounds).

(c) A laboratory shall report to the licensee or registrant and the Authority or the Commission, depending on which agency has jurisdiction, up to five tentatively identified compounds (TICS) that have the greatest apparent concentration.

(d) Match scores for background subtracted or deconvoluted spectra should exceed 90 percent compared to library spectrum.

(A) The top five matches over 90 percent must be reported by the lab

(B) TIC quantitation is estimated by comparing analyte area to the closest internal standard area and assuming a response factor (RF) =1.

(8) A laboratory must provide:

(a) Any pesticide test result to the Department of Agriculture upon that agency's request.

(b) A sample or a portion of a sample to the Department of Agriculture upon that agency's request, document the chain of custody from the laboratory to the Department, and document that the sample or portion of the sample was provided to the Department in the Commission's seed to sale tracking system.

(9) A laboratory performing tests for a licensee must enter any information required by the Commission in the Commission's seed to sale tracking system.

(10) A laboratory performing tests for a registrant must comply with the documentation requirements in OAR 333-007-0370.

(11) The Authority may, in its discretion, deviate from TNI Standards in order to comply with OAR 333-007-0400 to 333-007-0490 and these rules based on the state's needs.

Stat. Auth.: ORS 438.605, 438.610, 438.615 & 438.620, ORS 475B.555.
Stats. Implemented: ORS 438.605, 438.610, 438.615 & 438.620, ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

333-064-0110
Reporting Marijuana Test Results

(1) For purposes of this rule the definitions in OAR 333-007-0310 apply unless the context indicates otherwise.

(2) Within 24 hours of completion of the laboratory's data review and approval procedures a laboratory must report all failed tests for testing required under OAR 333-007-0300 to 333-007-0490 except for failed water activity, whether or not the lab is reanalyzing the sample under OAR 333-007-0450:

(a) Into the Commission's seed to sale tracking system if performing testing for a licensee; and

(b) To the Authority electronically at www.healthoregon.org/ommp if performing testing for a registrant.

(3) The laboratory must report all test results required under OAR 333-007-0300 to 333-007-0490 that have not been reported under section (2) of this rule into the Commission's seed to sale tracking system if performing testing for a licensee.

(4) A laboratory must determine and include on each test report its limit of quantification (LOQ) for each analyte listed in OAR 333-007-0400 Table 3 and OAR 333-007-0410 Table 4.

(5) When reporting pesticide testing results the laboratory must include in the report any target compound that falls below the LOQ that has a signal to noise ratio of greater than 3:1 and meets identification criteria with a result of "detected."

(6) A test report must include any associated test batch numbers and the date each test was completed.

(7) A laboratory that is reporting failed test results to the Commission or the Authority in accordance with section (2) of this rule must report the failed test at the same time or before reporting to the licensee or registrant.

(8) In addition to reporting failed test results in accordance with section (2) of this rule a laboratory conducting testing for a registrant must report to the Authority electronically at www.healthoregon.org/ommp any pesticide testing report with a "detected" as described in section (5) of this rule.

(9) Test results expire after one year.

Stat. Auth.: ORS 475B.555
Stats. Implemented: ORS 475B.555
Hist.: PH 22-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; PH 21-2016, f. 6-24-16, cert. ef. 6-28-16

Rule Caption: Hospital Nurse Staffing
Adm. Order No.: PH 22-2016
Filed with Sec. of State: 7-1-2016
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Rules Adopted: 333-510-0105, 333-510-0110, 333-510-0115, 333-510-0120, 333-510-0125, 333-510-0130, 333-510-0135, 333-510-0140
Rules Amended: 333-501-0035, 333-501-0040, 333-501-0045, 333-510-0002, 333-510-0045
Subject: The Oregon Health Authority, Public Health Division is permanently adopting and amending Oregon Administrative Rules relating to hospital nurse staffing in response to legislation (SB 469, Oregon Laws 2015, chapter 669) that was passed in the 2015 legislative session.

The proposed rulemaking clarifies rules regarding:
- Audit and complaint investigation procedures;
- Civil penalties for violations of nurse staffing laws;
- Nurse staffing law definitions;
- Hospital posting and record keeping requirements;
- Hospital nurse staffing committee requirements;
- Hospital nurse staffing plans and plan review requirements;
- Replacement nurse staffing requirements;
- Nursing staff member overtime;
- Waivers to nurse staffing plan requirements; and
- Minor housekeeping corrections for ease of readability and alignment with other state agency rules.

Rules Coordinator: Tracy Candela—(971) 673-0561

333-501-0035
Nurse Staffing Audit Procedure

(1) The Authority shall conduct an on-site audit of each hospital once every three years to determine compliance with the requirements of ORS 441.152 to 441.177 and 441.192. The Authority shall notify the hospital and both co-chairs of the hospital nurse staffing committee three business days in advance of the audit.

(2) During an audit, the Authority shall review any hospital record and conduct any interview or site visit that is necessary to determine that the hospital is in compliance with the requirements of ORS 441.152 to 441.177 and 441.192.

(3) In conducting an audit, the Authority shall interview:

(a) Both co-chairs of the hospital nurse staffing committee; and

(b) Any additional hospital staff members deemed necessary to determine compliance with applicable nurse staffing laws. Interviews may address, but are not limited to, the following topics:

(A) Implementation and effectiveness of the hospital-wide staffing plan for nursing services;

(B) Input, if any, provided to the hospital nurse staffing committee; or

(C) Any other fact relating to hospital nursing services subject to the Authority's review.

(4) In conducting an audit, the Authority may also interview:

(a) Hospital staff that does not voluntarily come forward for an interview during an audit; and

(b) Hospital patients or family members. Interviews may address, but are not limited to, any concerns or complaints related to nurse staffing in the hospital.

(5) Following an audit, the Authority shall issue a written survey report that communicates the results of the audit no more than 30 business days after the survey closes. This survey report:

(a) Shall be issued to the hospital and both co-chairs of the hospital nurse staffing committee; and

(b) May include a notice of civil penalties that complies with ORS 441.175 and OAR 333-501-0045.

(6) If the survey report identifies any area of noncompliance, the hospital shall submit a written plan to correct each identified deficiency. This plan:

(a) Shall be called the plan of correction;

(b) Shall be submitted no more than 30 business days after receiving the Authority's survey report; and

(c) Shall be evaluated by the Authority for sufficiency.

(7) No more than 30 business days after receipt of the hospital's plan of correction, the Authority shall issue a written determination that communicates whether the plan of correction is sufficient. This determination:

(a) Shall be issued to the hospital and both co-chairs of the hospital nurse staffing committee; and

(b) Shall require the hospital to either:

(A) Revise and resubmit the rejected plan of correction no more than 30 business days after receiving the Authority's determination that the plan is insufficient; or

(B) Implement the approved plan of correction no more than 45 business days after receiving the Authority's determination that the plan is sufficient.

(8) Following the approval of the plan of correction, the Authority shall conduct a second audit of the hospital to verify that the hospital has implemented the approved plan of correction. This audit shall be conducted within 60 business days of the plan of correction approval date.

(9) The identity of an individual providing evidence during an audit will be kept confidential to the extent permitted by law.

Stat. Auth.: ORS 413.042, 441.157 & 441.175
Stats. Implemented: ORS 441.157
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 22-2016, f. & cert. ef. 7-1-16

333-501-0040
Nurse Staffing Complaint Investigation Procedures

(1) The Authority shall conduct an unannounced on-site investigation of a hospital within 60 calendar days after receiving a valid complaint against the hospital for violating a provision of ORS 441.152 to 441.177. A complaint is valid when an allegation, if assumed to be true, would violate a requirement of ORS 441.152 to 441.177.

(2) During an investigation, the Authority shall review any hospital record and conduct any interview or site visit that is necessary to determine whether the hospital has violated a provision of ORS 441.152 to 441.177.

(3) In conducting an investigation, the Authority may:

(a) Review any documentation that may be relevant to the complaint, including patient records; and

(b) Interview any person who may have information relevant to the complaint, including patients and family members.

(4) In reviewing information collected during an investigation, the Authority shall consider:

(a) The amount and strength of objective evidence, if any, that substantiates or refutes the complaint; and

(b) The number and credibility of witnesses, if any, who attest to or refute an alleged violation.

(5) Following an investigation, the Authority shall issue a written investigation report that communicates the results of the investigation no more than 30 business days after the investigation closes. This investigation report:

(a) Shall be issued to the hospital and both co-chairs of the hospital nurse staffing committee; and

(b) May include a notice of civil penalties that complies with ORS 441.175 and OAR 333-501-0045.

(6) If the investigation report identifies any area of noncompliance, the hospital shall submit a written plan to correct each identified deficiency. This plan:

(a) Shall be called the plan of correction;

(b) Shall be submitted no more than 30 business days after receiving the Authority's investigation report; and

(c) Shall be evaluated by the Authority for sufficiency.

(7) No more than 30 business days after receipt of the hospital's plan of correction, the Authority shall issue a written determination that communicates whether the plan of correction is sufficient. This determination:

(a) Shall be issued to the hospital and both co-chairs of the hospital nurse staffing committee; and

(b) Shall require the hospital to either:

(A) Revise and resubmit the rejected plan of correction no more than 30 business days after receiving the Authority's determination that the plan is insufficient; or

(B) Implement the approved plan of correction no more than 45 business days after receiving the Authority's determination that the plan is sufficient.

(8) Following the approval of the plan of correction, the Authority shall conduct a second investigation of the hospital to verify that the hospital has implemented the approved plan of correction. This investigation shall be conducted within 60 business days of the plan of correction approval date.

(9) The identity of an individual providing evidence during an investigation will be kept confidential to the extent permitted by law.

Stat. Auth.: ORS 413.042, 441.025, 441.057, 441.171 & 441.175
Stats. Implemented: ORS 441.057 & 441.171
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 22-2016, f. & cert. ef. 7-1-16

333-501-0045
Civil Penalties for Violations of Nurse Staffing Laws

(1) For the purposes of this rule, "safe patient care" has the meaning given to the term in OAR 333-510-0002.

(2) The Authority may impose civil penalties for a violation of any provision of ORS 441.152 to 441.177 and 441.185 if there is a reasonable belief that safe patient care has been or may be negatively impacted.

(3) Each violation of the written hospital-wide staffing plan shall be considered a separate violation.

(4) If imposed, the Authority will issue civil penalties in accordance with Table 1 of this rule.

(5) In determining whether to issue a civil penalty, the Authority will consider all relevant evidence including, but not limited to, witness testimony, written documents and observations.

(6) A civil penalty imposed under this rule shall comply with ORS 183.745.

(7) The Authority shall maintain for public inspection records of any civil penalties imposed on hospitals penalized under this rule.

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

Stat. Auth.: ORS 413.042, 441.175 & 441.185
Stats. Implemented: ORS 441.175 & 441.185
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 22-2016, f. & cert. ef. 7-1-16

333-510-0002
Definitions

As used in OAR chapter 333, division 510, the following definitions apply:

(1) "Direct Care Registered Nurse" means a nurse who is routinely assigned to a patient care unit, who is replaced for scheduled and unscheduled absences and includes charge nurses if the charge nurse is not management services.

(2) "Direct Care Staff" means registered nurses, licensed practical nurses and certified nursing assistants that are routinely assigned to patient care units and are replaced for scheduled or unscheduled absences.

(3) "Direct Care Staff Member" means an individual who is a direct care registered nurse, licensed practical nurse or certified nursing assistant who is routinely assigned to a patient care unit and is replaced for a scheduled or unscheduled absences.

(4) "Epidemic" means the occurrence of a group of similar conditions of public health importance in a community or region that are in excess of normal expectancy and that are from a common or propagated source.

(5) "Evidence Based Standards" means standards that have been scientifically developed, are based on current literature, and are driven by consensus.

(6) "Hospital" means a hospital as described in ORS 442.015 and an acute inpatient care facility as defined in ORS 442.470.

(7) "Mandatory Overtime" is any time that exceeds those time limits specified in ORS 441.166 unless the nursing staff member voluntarily chooses to work overtime.

(8) "Nurse Manager" means a registered nurse who has administrative responsibility 24 hours a day, 7 days a week for a patient care unit, units or hospital and who is not replaced for short-term scheduled or unscheduled absences.

(9) "Nursing care intensity" means the level of patient need for nursing care as determined by the nursing assessment.

(10) "Nursing staff" means registered nurses, licensed practical nurses and certified nursing assistants.

(11) "Nursing staff member" means an individual who is a registered nurse, licensed practical nurse or a certified nursing assistant.

(12) "On Call" means a scheduled state of availability to return to duty, work-ready, within a specified period of time.

(13) "On Call Nursing Staff" means individual nursing staff members or nursing service agencies maintained by a hospital that are available and willing to cover nursing staff shortages due to unexpected nursing staff absences or unanticipated increased nursing service needs.

(14) "Patient acuity" means the complexity of patient care needs requiring the skill and care of nursing staff.

(15) "Potential Harm" or "At Risk of Harm" means that an unstable patient will be left without adequate care for an unacceptable period of time if the assigned nursing staff member leaves the assignment or transfers care to another nursing staff member.

(16) "Quorum" means that a majority, or one-half plus one, of the staffing committee members are present during a staffing committee meeting.

(17) "Safe Patient Care" means nursing care that is provided appropriately, in a timely manner, and meets the patient's health care needs. The following factors may be, but are not in all circumstances, evidence of unsafe patient care:

(a) A failure to implement the written nurse staffing plan;

(b) A failure to comply with the patient care plan;

(c) An error that has a negative impact on the patient;

(d) A patient report that his or her nursing care needs have not been met;

(e) A medication not given as scheduled;

(f) The nursing preparation for a procedure that was not accomplished on time;

(g) A nursing staff member who was practicing outside his or her authorized scope of practice;

(h) Daily unit-level staffing that does not include coverage for all known patients, taking into account the turnover of patients;

(i) The skill mix of employees and the relationship of the skill mix to patient acuity and nursing care intensity of the workload is insufficient to meet patient needs; or

(j) An unreasonable delay in responding to a request for nursing care made by a patient or made on behalf of a patient by his or her family member.

(18) "Staffing Committee" means the hospital nurse staffing committee.

(19) "Staffing Plan" means the written hospital-wide staffing plan for nursing services developed by the hospital nurse staffing committee.

(20) "Standby" means a scheduled state of availability to return to duty, work-ready within a specified period of time.

(21) "Waiver" means a variance to the hospital-wide staffing plan requirements as described in ORS 441.164.

Stat. Auth.: ORS 413.042 & 441.151 – 441.177
Stats. Implemented: ORS 441.165, 441.166 & 441.179
Hist.: PH 21-2006, f. & cert. ef. 10-6-06; PH 11-2009, f. & cert. ef. 10-1-09; PH 22-2016, f. & cert. ef. 7-1-16

333-510-0045
Nurse Staffing Posting and Record Requirements

(1) On each hospital unit, a hospital shall post a complaint notice that:

(a) Summarizes the provisions of ORS 441.152 to 441.177;

(b) Is clearly visible to the public; and

(c) Includes the Authority's complaint reporting phone number, electronic mail address and website address.

(2) A hospital shall also post an anti-retaliation notice on the premises that:

(a) Summarizes the provisions of ORS 441.181, 441.183, 441.184 and 441.192;

(b) Is clearly visible; and

(c) Is posted where notices to employees and applicants for employment are customarily displayed.

(3) A hospital shall keep and maintain all records necessary to demonstrate compliance with ORS 441.152 to 441.177. These records shall:

(a) Be maintained for no fewer than three years;

(b) Be promptly provided to the Authority upon request; and

(c) Include, at minimum:

(A) The staffing plan;

(B) The hospital nurse staffing committee charter;

(C) Staffing committee meeting minutes;

(D) Documentation showing how all members of the staffing committee were selected;

(E) All complaints filed with the staffing committee;

(F) Personnel files for all nursing staff positions that include, at minimum, job descriptions, required licensure and specialized qualifications and competencies required for the individual's assigned nurse specialty or unit;

(G) Documentation showing work schedules for nursing staff in each hospital nurse specialty or unit;

(H) Documentation showing actual hours worked by all nursing staff;

(I) Documentation showing all work schedule variances that resulted in the use of replacement nursing staff;

(J) Documentation showing how many on-call hours, if any, required nursing staff to be on the hospital premises;

(K) Documentation showing how many required meeting, education and training hours, if any, were required of nursing staff;

(L) The hospital's mandatory overtime policy and procedure;

(M) Documentation showing how many, if any, overtime hours were worked by nursing staff;

(N) Documentation of all waiver requests, if any, submitted to the Authority;

(O) Documentation showing how many, if any, additional hours were worked due to emergency circumstances and the nature of those circumstances;

(P) The list of on-call nursing staff used to obtain replacement nursing staff;

(Q) Documentation showing how and when the hospital updates its list of on-call staff used to obtain replacement nursing staff and how the hospital determines eligibility to remain on the list;

(R) Documentation showing the hospital's procedures for obtaining replacement nursing staff, including efforts made to obtain replacement staff;

(S) Documentation showing the hospital's actual efforts to seek replacement staff when needed;

(T) Documentation showing each actual instance in which the hospital implemented the policy described in OAR 333-510-0110(2)(g) to initiate limitations on admission or diversion of patients to another hospital; and

(U) All staffing committee reports filed with the hospital administration following a review of the staffing plan.

Stat. Auth.: ORS 413.042, 441.155, 441.169, 441.173 & 441.185
Stats. Implemented: ORS 441.155, 441.169, 441.173 & 441.185
Hist.: OHD 2-2000, f. & cert. ef. 2-15-00; OHD 3-2001, f. & cert. ef. 3-16-01; OHD 20-2002, f. & cert. ef. 12-10-02; PH 22-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-29-06; PH 21-2006, f. & cert. ef. 10-6-06; PH 11-2009, f. & cert. ef. 10-1-09; PH 11-2009, f. & cert. ef. 10-1-09; PH 22-2016, f. & cert. ef. 7-1-16

333-510-0105
Nurse Staffing Committee Requirement

(1) Each hospital shall establish and maintain a hospital nurse staffing committee. The staffing committee shall develop a written hospital-wide staffing plan for nursing services in accordance with ORS 441.155 and OAR chapter 333, division 510 rules. In developing the staffing plan, the staffing committee's primary goal shall be to ensure that the hospital is adequately staffed to meet the health care needs of its patients.

(2) The staffing committee shall meet:

(a) At least once every three months; and

(b) At any time and place specified by either co-chair of the staffing committee.

(3) The hospital shall release a member of the staffing committee from his or her assignment to attend committee meetings and provide paid time for this purpose.

(4) The staffing committee shall be comprised of an equal number of hospital nurse managers and direct care staff. Direct care staff members shall be selected as follows:

(a) The staffing committee shall include at least one direct care registered nurse from each hospital nurse specialty or unit as the specialty or unit is defined by the hospital to represent that specialty or unit;

(b) In addition to the direct care registered nurses described in subsection (a) of this section there must be one position on the staffing committee that is filled by a direct care staff member who is not a registered nurse and whose services are covered by the staffing plan;

(c) If the direct care registered nurses working at the hospital are represented under a collective bargaining agreement, the bargaining unit shall coordinate voting to allow the direct care registered nurses who work at the hospital to select each direct care registered nurse on the staffing committee;

(d) If the direct care registered nurses working at the hospital are not represented under a collective bargaining agreement, the direct care registered nurses belonging to each hospital nurse specialty or unit shall select the direct care registered nurse to represent it on the staffing committee; and

(e) If the position that must be filled by a direct care staff member who is not a registered nurse and whose services are covered by the staffing plan is represented under a collective bargaining agreement, the bargaining unit shall coordinate voting to allow the direct care staff members who are not registered nurses to select the direct care staff member who is not a registered nurse to represent them on the staffing committee.

(f) If the position that must be filled by a direct care staff member who is not a registered nurse and whose services are covered by the staffing plan is not represented under a collective bargaining agreement, the direct care staff members who are not registered nurses shall select the direct care staff member who is not a registered nurse to represent them on the staffing committee.

(5) The staffing committee shall have two co-chairs. One co-chair must be a hospital nurse manager elected by a majority of the staffing committee members who are hospital nurse managers. The other co-chair must be a direct care registered nurse elected by a majority of the staffing committee members who are direct care staff.

(6) The staffing committee must develop a written charter that documents the policies and procedures of the staffing committee. At minimum, the charter must include:

(a) How meetings are scheduled;

(b) How members are notified of meetings;

(c) How agendas are determined;

(d) How input from hospital nurse specialty or unit staff is submitted;

(e) Who may participate in decision-making;

(f) How decisions are made; and

(g) How the staffing committee shall monitor, evaluate and modify the staffing plan over time.

(7) Staffing committee meetings must be conducted as follows:

(a) A meeting may not be conducted unless a quorum of staffing committee members is present;

(b) Except as set forth in subsection (c) of this section, a meeting must be open to all hospital nursing staff as observers and to any other individual as either observer or presenter by invitation of either co-chair of the staffing committee;

(c) Either co-chair of the staffing committee may temporarily exclude all non-members from a meeting during staffing committee deliberations and voting; and

(d) Each staffing committee decision must be made by majority vote; however, if a quorum consists of an unequal number of hospital nurse managers and direct care staff, only an equal number of hospital nurse managers and direct care staff may vote.

(8) The staffing committee must document meeting proceedings by keeping written meeting minutes that include, but are not limited to, the following information:

(a) The name and position of each staffing committee member in attendance;

(b) The name and position of each observer or presenter in attendance;

(c) Motions made;

(d) Outcomes of votes taken;

(e) A summary of staffing committee discussions; and

(f) Instances in which non-members have been excluded from staffing committee meetings.

(9) The staffing committee shall approve meeting minutes prior to or during the next staffing committee meeting.

(10) The staffing committee shall provide meeting minutes to hospital nursing staff and other hospital staff upon request no more than 30 calendar days after the meeting minutes are approved by the staffing committee.

Stat. Auth.: ORS 413.042, 441.151 & 441.154
Stats. Implemented: ORS 441.154
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0110
Nurse Staffing Plan Requirements

(1) Each hospital shall implement a written hospital-wide staffing plan for nursing services that is developed and approved by the hospital nurse staffing committee established in accordance with ORS 441.154 and OAR chapter 333 division 510 rules.

(2) The staffing plan:

(a) Must be based on the specialized qualifications and competencies of the nursing staff and provide for the skill mix and level of competency necessary to ensure that the hospital is staffed to meet the health care needs of patients;

(b) Must be based on a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit;

(c) Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses;

(d) Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations such as, but not limited to: The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN);

(e) Must recognize differences in patient acuity and nursing care intensity;

(f) Must establish minimum numbers of nursing staff, including licensed practical nurses and certified nursing assistants, required on specified shifts, provided that no fewer than one registered nurse and one other nursing staff member is on duty in a unit when a patient is present;

(g) Must include a formal process for evaluating and initiating limitations on admission or diversion of patients to another hospital when, in the judgment of a direct care registered nurse or a nurse manager, there is an inability to meet patient care needs or a risk of harm to patients;

(h) Must consider tasks not related to providing direct care, including meal breaks and rest breaks;

(i) May not base nursing staff requirements solely on external benchmarking data;

(j) May not be used by a hospital to impose upon unionized nursing staff any changes in wages, hours or other terms and conditions of employment unless the hospital first provides notice to and, upon request, bargains with the union; and

(k) May not create, preempt or modify a collective bargaining agreement or require parties to an agreement to bargain over the staffing plan while a collective bargaining agreement is in effect.

Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0115
Nurse Staffing Plan Review Requirement

(1) The staffing committee shall:

(a) Review the staffing plan at least once per year; and

(b) At any other time specified by either co-chair of the staffing committee.

(2) In reviewing the staffing plan, the staffing committee shall consider:

(a) Patient outcomes;

(b) Complaints regarding staffing, including complaints about a delay in direct care nursing or an absence of direct care nursing;

(c) The number of hours of nursing care provided through a hospital unit compared with the number of patients served by the hospital unit during a 24-hour period;

(d) The aggregate hours of mandatory overtime worked by nursing staff;

(e) The aggregate hours of voluntary overtime worked by nursing staff;

(f) The percentage of shifts for each hospital unit for which staffing differed from what is required by the staffing plan;

(g) Any other matter determined by the committee to be necessary to ensure that the hospital is staffed to meet the health care needs of patients; and

(h) Any report filed by a nursing staff member stating the nursing staff member's belief that the hospital unit engaged in a pattern of requiring direct care nursing staff to work overtime for nonemergency care.

(3) Following its review of the staffing plan, the staffing committee shall issue a written report to the hospital that indicates whether the staffing plan ensures that the hospital is adequately staffed and meets the health care needs of patients. If the report indicates that it does not, the staffing committee shall modify the staffing plan as necessary to accomplish this goal.

Stat. Auth.: ORS 413.042 & 441.156
Stats. Implemented: ORS 441.156
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0120
Nurse Staffing Plan Mediation

(1) If the staffing committee is unable to reach an agreement on the staffing plan, either co-chair of the staffing committee may invoke a waiting period of 30 business days.

(a) During the 30-day waiting period, the staffing committee shall continue to develop the staffing plan; and

(b) The hospital shall promptly respond to any reasonable requests for data that is related to the impasse and is submitted by either co-chair of the staffing committee.

(2) If at the end of the 30-day waiting period, the staffing committee remains unable to reach an agreement on the staffing plan, one of the staffing committee co-chairs shall notify the Authority of the impasse. This notification shall include:

(a) Documentation that the staffing committee voted on the provision or provisions in question and a deadlock resulted;

(b) Documentation that either co-chair of the staffing committee formally invoked a 30-day waiting period;

(c) Documentation that during the 30-day waiting period, the staffing committee continued to develop the staffing plan including documentation of options the staffing committee considered after invoking the 30-day waiting period;

(d) Documentation of any reasonable requests for data submitted to the hospital by either staffing committee co-chair and the hospital's response, if any; and

(e) Documentation that the staffing committee voted on the provision or provisions in question again after the 30-day waiting period formally ended and another deadlock resulted.

(3) No more than 15 business days after receiving notice of an impasse, the Authority shall assign the staffing committee a mediator to assist the staffing committee in reaching an agreement on the staffing plan.

(a) Mediation shall be consistent with requirements for implementing and reviewing staffing plans set forth in ORS 441.155 and 441.156 and OAR chapter 333 division 510 rules; and

(b) Mediation shall be provided for no more than 90 calendar days.

(4) The Authority may impose civil monetary penalties against a hospital, if the staffing committee is unable to reach an agreement on the staffing plan after 90 days of mediation.

Stat. Auth.: ORS 413.042, 441.154 & 441.175
Stats. Implemented: ORS 441.154
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0125
Replacement Nurse Staffing Requirements

(1) A hospital must maintain and post or publish a list of on-call nursing staff that may be contacted to provide qualified replacement or additional nursing staff in the event of a vacancy or unexpected shortage. This list must:

(a) Provide for sufficient replacement nursing staff on a regular basis; and

(b) Be available to the individual who is responsible for obtaining replacement staff during each shift.

(2) When developing and maintaining the on-call list, the hospital must explore all reasonable options for identifying local replacement staff and these efforts must be documented.

(3) When a hospital learns about the need for replacement nursing staff, the hospital must make every reasonable effort to obtain adequate voluntary replacement nursing staff for unfilled hours or shifts before requiring a nursing staff member to work overtime and these efforts must be documented. Reasonable efforts include, but are not limited to:

(a) The hospital seeking replacement nursing staff at the time the vacancy is known; and

(b) The hospital contacting all available resources on its list of on-call nursing staff as described in this rule.

Stat. Auth.: ORS 413.042, 441.155 & 441.166
Stats. Implemented: ORS 441.155 & 441.166
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0130
Nursing Staff Member Overtime

(1) For purposes of this rule "require" means hours worked as a condition of employment whether as a result of a previously scheduled shift or hours actually worked during time spent on call or on standby.

(2) A hospital may not require a nursing staff member to work:

(a) Beyond the agreed-upon and prearranged shift, regardless of the length of the shift;

(b) More than 48 hours in any hospital-defined work week;

(c) More than 12 hours in a 24-hour period; or

(d) During the 10-hour period immediately following the 12th hour worked during a 24-hour period. This work period begins when the nursing staff member begins a shift.

(3) Nothing in this rule precludes a nursing staff member from volunteering to work overtime.

(4) A hospital may require an additional hour of work beyond the hours authorized in section (2) of this rule if:

(a) A staff vacancy for the next shift becomes known at the end of the current shift; or

(b) There is a potential harm to an assigned patient if the nursing staff member leaves the assignment or transfers care to another nursing staff member.

(5) Each hospital must have a policy and procedure in place to ensure, at minimum, that:

(a) Mandatory overtime, when required, is documented in writing;

(b) Mandatory overtime policies and procedures are clearly written, provided to all new nursing staff and readily available to all nursing staff;

(c) Time spent by the nursing staff member in required meetings or receiving education or training will be included as hours worked for the purpose of section (2) of this rule;

(d) Time spent on call or on standby when the nursing staff member is required to be at the hospital will be included as hours worked for the purpose of section (2) of this rule; and

(e) Time spent on call or on standby when the nursing staff member is not required to be at the hospital will not be included as hours worked for the purpose of section (2) of this rule.

(6) If a nursing staff member believes that a hospital unit is engaging in a pattern of requiring direct care nursing staff to work overtime for non-emergency care, the nursing staff member may report that information to the staffing committee. The staffing committee shall consider the information when reviewing the staffing plan as described in OAR 333-510-0115.

(7) The provisions of sections (2) through (5) of this rule do not apply to nursing staff needs:

(a) In the event of a national or state emergency or circumstances requiring the implementation of a facility disaster plan; or

(b) In emergency circumstances that include:

(A) Sudden and unforeseen adverse weather conditions;

(B) An infectious disease epidemic suffered by hospital staff;

(C) Any unforeseen event preventing replacement staff from approaching or entering the premises; or

(D) Unplanned direct care staff vacancies of 20% or more of the nursing staff for the next shift hospital-wide at the Oregon State Hospital if, based on the patient census, the Oregon State Hospital determines the number of direct care staff available hospital-wide cannot ensure patient safety.

(8) Nothing in section (6) of this rule relieves the Oregon State Hospital from contacting voluntary replacement staff as described in OAR 333-510-0125 and documenting these contacts.

(9) A registered nurse at a hospital may not place a patient at risk of harm by leaving a patient care assignment during an agreed upon scheduled shift or an agreed-upon extended shift without authorization from the appropriate supervisory personnel as required by the Oregon State Board of Nursing OAR, chapter 851.

(10) Until the Authority defines "other nursing staff" as that term is described in ORS 441.166(1), this rule applies only to "nursing staff member" as that term is defined in these rules.

Stat. Auth.: ORS 413.042, 441.166 & 441.168
Stats. Implemented: ORS 441.155 & 441.165
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0135
Nurse Staffing Plan Waiver

(1) At a hospital's request, the Authority may waive any staffing plan requirement set forth in ORS 441.155 provided that a waiver is necessary to ensure that the hospital is staffed to meet the health care needs of its patients.

(2) All requests for a waiver must:

(a) Be submitted to the Authority in writing;

(b) State the reason or reasons for which the hospital is seeking the waiver;

(c) Explain how the waiver is necessary for the hospital to meet patient health care needs; and

(d) Include verification that the hospital notified the staffing committee of the request for a waiver prior to its submission.

Stat. Auth.: ORS 413.042 & 441.165
Stats. Implemented: ORS 441.155 & 441.165
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0140
Nurse Staffing Plan During an Emergency

(1) A hospital is not required to follow the staffing plan developed and approved by the staffing committee in the event of:

(a) A national or state emergency requiring the implementation of a facility disaster plan;

(b) Sudden and unforeseen adverse weather conditions; or

(c) An infectious disease epidemic suffered by hospital staff.

(2) In the event of an emergency circumstance not described in section (1) of this rule, either co-chair of the staffing committee may specify a time and place to meet to review and potentially modify the staffing plan in response to the emergency circumstance.

Stat. Auth.: ORS 413.042 & 441.165
Stats. Implemented: ORS 441.155 & 441.165
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

Oregon Housing and Community Services Department
Chapter 813

Rule Caption: Amends definitions to include the General Housing Account and regulatory agreements, clarifies process for protests
Adm. Order No.: OHCS 6-2016(Temp)
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 6-29-16 thru 12-25-16
Notice Publication Date:
Rules Adopted: 813-005-0025
Rules Amended: 813-005-0005
Subject: The rules are amended to include the General Housing Account as a housing program administered by the department, amends the definition for loan documents and expands the definition for NOFA. The rules also add a definition for regulatory agreement as to project management or management agreement. A new rule has been adopted to establish the process for an applicant or potential qualifying applicant to protest or challenge a solicitation offered by the department.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

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) Agriculture Workforce 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) General Housing Account (OAR 813-055);
(r) Disabled Housing Program (OAR 813-060);
(s) Home Improvement Loan Program (OAR 813-070);
(t) Mortgage Credit Certificate Program (OAR 813-080);
(u) Low-Income Housing Tax Credit Program (OAR 813-090);
(v) Oregon Affordable Housing Tax Credit Program (OAR 813-110);
(w) Home Investment Partnerships Program (OAR 813-120);
(x) HELP Program (OAR 813-130);
(y) Incentive Fund Program (OAR 813-140);
(z) Subsidized Development Visitability Program (OAR 813-310);
(aa) General Guarantee Program (OAR 813-350); and
(bb) 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 Housing Stability 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 Housing Stability 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 Housing Stability 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 Stability 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 possibly others) and the department or in favor of the department, typically executed at loan closing, with respect to a department loan and generally including, but not necessarily limited to the promissory note, the loan agreement, the trust deed and the regulatory or operating 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 and constitutes a solicitation document as hereinafter defined.

(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) "Regulatory Agreement as to Project Management" or "Management Agreement" means a written agreement typically executed at or after loan closing between the department, a project sponsor and, if applicable, a management agent engaged by the sponsor regulating certain aspects of project management to ensure, inter alia, accomplishment of program requirements.

(38) "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.

(39) "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.

(40) "Seed money advance" means an advance given to a qualified housing sponsor to pay preconstruction costs.

(41) "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.

(42) "Solicitation" means a process by which the department invites applications for a housing grant or other funding award with respect to a project.

(43) "Solicitation documents" means those documents that, inter alia, set forth the terms and conditions of a solicitation.

(44) "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.

(45) "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.

(46) "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; OHCS 18-2013, f. & cert. ef. 12-18-13; OHCS 25-2014(Temp), f. & cert. ef. 4-17-14 thru 10-14-14; OHCS 34-2014, f. & cert. ef. 10-9-14; OHCS 6-2016(Temp), f. & cert. ef. 6-29-16 thru 12-25-16

813-005-0025

Solicitation Protests; Administrative and Judicial Review

(1)(a) With respect to any solicitation conducted by the department, an applicant or potential qualifying applicant may protest or otherwise challenge such solicitation process by first requesting administrative review as herein specified.

(b) With respect to any solicitation conducted by the department, an applicant may protest or otherwise challenge any department determination or order (collectively hereinafter, "determination") related to such solicitation by first requesting administrative review as herein specified.

(c) A timely, qualifying request for administrative review is necessary to satisfy the conditions of this section and a condition precedent to judicial review consistent with ORS 183.480.

(d) Failure to file a timely, qualifying request for administrative review with the department will constitute a failure to exhaust administrative remedies and terminate further rights to protest or otherwise challenge the solicitation process or any related department determination, including judicial review thereof.

(2)(a) An applicant under this section is a person or entity that makes an application (including delivery to the department under the terms of the solicitation) for a department funding award pursuant to a particular department solicitation.

(b) A potential qualifying applicant is a person or entity that qualifies to make an application for a department funding award under the terms of a solicitation with respect to the process of which it requests administrative review consistent with the terms of this section.

(3)(a) An applicant or potential qualifying applicant seeking to protest or otherwise challenge any aspect of a solicitation process (other than a department determination related thereto) must request review by the department within fourteen (14) days of the application due date of the solicitation.

(b) An applicant seeking to protest or otherwise challenge a determination by the department related to a solicitation must request review by the department of such determination within fourteen (14) days of the applicant receiving notice from the department of that determination.

(4) Any request for review under this section must be in writing, specifically identifying:

(a) The nature of the requestor's interest, including the facts showing how the requestor is adversely affected or aggrieved by the solicitation process or a department determination;

(b) The relief sought;

(c) Each of the grounds for review;

(d) An explanation for each of the grounds upon which relief should be granted; and

(e) Any supporting information the requestor desires to have considered by the department.

(5) The envelope containing the request for review MUST:

(a) Be marked PROTEST;

(b) Identify the solicitation number;

(c) Identify the closing time and date for acceptance of solicitation applications;

(d) Identify the department's contact person for the solicitation; and

(e) Be received by the department at its main Salem Office, Oregon Housing and Community Services, 725 Summer Street NE, Suite B, Salem, OR 97301, not later than **4:00 PM** on the **fourteenth(14th) day** after the solicitation closing date or the applicant's receipt of notice from the department of the department determination from which review is requested, whichever due date is applicable under this section.

(6) The applicant will be deemed to have received notice of a department determination upon the sooner of:

(a) Three (3) days after the department's determination is mailed to the applicant;

(b) Two (2) days after such determination is posted to the department's website;

(c) Two (2) days after the list of successful solicitation applicants is posted to the department's website; or

(d) One (1) day after such determination is emailed to the applicant.

(7) The department may request additional information from the requestor with respect to its request and consider such other information as it deems appropriate.

(8) The department will endeavor to provide a written response to a timely, qualifying request for review within thirty (30) days.

(9) Judicial review of the department response to a timely, qualifying request for review shall be limited to those grounds the requestor raised with the department in its request for review.

(10) The filing of a request for review, or subsequent judicial review (if any), will not preclude the department from moving forward with the solicitation or the award of funding assistance thereunder. However, the department reserves the right to delay, terminate, modify, or take other action it determines to be appropriate with respect to a solicitation or any related award of funding assistance in response to a request for review or subsequent judicial review.

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.: OHCS 6-2016(Temp), f. & cert. ef. 6-29-16 thru 12-25-16

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Rule Caption: Amends the purpose rule for public contracts and provides clarification relating to competitive procurement

Adm. Order No.: OHCS 7-2016(Temp)

Filed with Sec. of State: 6-29-2016

Certified to be Effective: 6-29-16 thru 12-25-16

Notice Publication Date:

Rules Amended: 813-006-0005, 813-006-0010

Subject: Division 6 establishes the general procedures for public contracts by the department as well as other contracting and procurement activities. The amended temporary rules reflect a change in the title for this set of rules. The purpose rule has been amended to clarify that these are the general procedures adopted by the agency. The rules for basic policy and approach have been amended to reflect that the department will ensure competition and include performance standards to the maximum extent practicable to include contracts for goods and services as the department deems appropriate or otherwise required by law. The rules are also amended to clarify that a preference will be given to maximizing program objectives in a selection process between two or more equally qualified bidders in a competitive procurement.

Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-006-0005

Purpose

OAR chapter 813, division 6 is promulgated to establish general 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 the code 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; OHCS 24-2013, f. & cert. ef. 12-18-13; OHCS 7-2016(Temp), f. & cert. ef. 6-29-16 thru 12-25-16

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;

(d) Ascertaining and obtaining appropriate representations and warranties as to the qualifications of parties;

(e) Specificity with respect to consideration and applicable time periods;

(f) Specificity with respect to terms and covenants, particularly as to standards applicable to the performance of all work or delivery of goods;

(g) Identification of remedies and their suitability to protect Department and program interests;

(h) Identification of insurance and other risk mitigation terms and the appropriate balance of such measures with potential risks and costs;

(i) Requirements for compliance with applicable laws, including those applicable to funding sources and nondiscrimination;

(j) 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 may be more fully set forth in the divisions of OAR chapter 813 that specifically address those programs. Relevant general procedures, requirements and standards are set forth herein and 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:

(a) When the specialized skills, knowledge, and resources are not available within the Department;

(b) When the work cannot be done in a reasonable time within the Department's own work force;

(c) 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;

(d) When it will be less expensive to contract for the work;

(e) When the Department is directed by statute or otherwise to contract for services; or

(f) 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 contracts for goods and services, personal services contracts and, as the department deems appropriate or otherwise required by law, financial assistance awards and related funding agreements (particularly when designed, inter alia, to obtain services in furtherance of a Department-supervised program).

(8) In selecting between two or more equally qualified bidders in a competitive procurement, preference will be given to maximizing program objectives, 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; OHCS 24-2013, f. & cert. ef. 12-18-13; OHCS 7-2016(Temp), f. & cert. ef. 6-29-16 thru 12-25-16

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Oregon Liquor Control Commission
Chapter 845

Rule Caption: The rules permanently adopt Division 25 rules for Recreational Marijuana.

Adm. Order No.: OLCC 6-2016

Filed with Sec. of State: 6-28-2016

Certified to be Effective: 6-29-16

Notice Publication Date: 5-1-2016

Rules Adopted: 845-025-1000, 845-025-1015, 845-025-1030, 845-025-1045, 845-025-1060, 845-025-1070, 845-025-1080, 845-025-1090, 845-025-1100, 845-025-1115, 845-025-1130, 845-025-1145, 845-025-1160, 845-025-1175, 845-025-1190, 845-025-1200, 845-025-1215, 845-025-1230, 845-025-1245, 845-025-1260, 845-025-1275, 845-025-1290, 845-025-1295, 845-025-1300, 845-025-1330, 845-025-1360, 845-025-1400, 845-025-1405, 845-025-1410, 845-025-1420, 845-025-1430, 845-025-1440, 845-025-1450, 845-025-1460, 845-025-1470, 845-025-1600, 845-025-1620, 845-025-2000, 845-025-2020, 845-025-2030, 845-025-2040, 845-025-2050, 845-025-2060, 845-025-2070, 845-025-2080, 845-025-2800, 845-025-2820, 845-025-2840, 845-025-2860, 845-025-2880, 845-025-2890, 845-025-3200, 845-025-3210, 845-025-3215, 845-025-3220, 845-025-3230, 845-025-3240, 845-025-3250, 845-025-3260, 845-025-3280, 845-025-3290, 845-025-3500, 845-025-5000, 845-025-5030, 845-025-5045, 845-025-5060, 845-025-5075, 845-025-5300, 845-025-5350, 845-025-5500, 845-025-5520, 845-025-5540, 845-025-5560, 845-025-5580, 845-025-5590, 845-025-5700, 845-025-5720, 845-025-5730, 845-025-5740, 845-025-5760, 845-025-5790, 845-025-7000, 845-025-7020, 845-025-7030, 845-025-7040, 845-025-7060, 845-025-7500, 845-025-7520, 845-025-7540, 845-025-7560, 845-025-7570, 845-025-7580, 845-025-7590, 845-025-7700, 845-025-7750, 845-025-8000, 845-025-8020, 845-025-8040, 845-025-8060, 845-025-8080, 845-025-8500, 845-025-8520, 845-025-8540, 845-025-8560, 845-025-8570, 845-025-8580, 845-025-8590, 845-025-8700

Subject: On November 4, 2014, Oregon voters passed the "Control, Regulation and Taxation of Marijuana and Industrial Hemp Act of 2014" ("Measure 91"). This measure effectively decriminalizes certain aspects of the production, sale and personal use of recreational marijuana within the state. From approximately January through June 2015, the Oregon legislature considered numerous pieces of legislation to revise Measure 91. On June 30, 2015, Oregon's Governor Kate Brown signed House Bill 3400 ("HB 3400") into law, which amended a majority of Measure 91's provisions. Further, HB 3400 effectively set the scope of the Commission's authority and responsibilities to implement a recreational marijuana regulatory system.

In October 2015, the Commission adopted temporary administrative rules to regulate the recreational marijuana industry as directed by HB 3400 and Measure 91. The draft rules were developed based on advisory committee recommendations, staff interpretation of HB 3400, and input provided by other state agencies, local governments, and interested parties. The proposed permanent rules incorporate staff's evolving understanding of the issues as well as additional input from the Rule Advisory Committee and comments from the public.

Rules Coordinator: Bryant Haley—(503) 872-5136

845-025-1000
Applicability

(1) A person may not produce, process, store, transport, sell, sample, test, or deliver marijuana for commercial recreational use without a license from the Commission or as otherwise authorized under these rules.

(2) Nothing in these rules exempts a licensee or licensee representative from complying with any other applicable state or local laws.

(3) Licensure under these rules does not protect a person from possible criminal prosecution under federal law.

Stat. Auth.: ORS 475B.025

Stats. Implemented: ORS 475B.070, 475B.070, 475B.090, 475B.100, 475B.110, 475B.340, 475B.020 & 475B.560

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1015
Definitions

For the purposes of OAR 845-025-1000 to 845-025-8590, unless otherwise specified, the following definitions apply:

(1) "Adulterated" means to make a marijuana item impure by adding foreign or inferior ingredients or substances. A marijuana item may be considered to be adulterated if:

(a) It bears or contains any poisonous or deleterious substance in a quantity rendering the marijuana item injurious to health, including but not limited to tobacco or nicotine;

(b) It bears or contains any added poisonous or deleterious substance exceeding a safe tolerance if such tolerance has been established;

(c) It consists in whole or in part of any filthy, putrid, or decomposed substance, or otherwise is unfit for human consumption;

(d) It is processed, prepared, packaged, or is held under improper time-temperature conditions or under other conditions increasing the probability of contamination with excessive microorganisms or physical contaminants;

(e) It is processed, prepared, packaged, or held under insanitary conditions increasing the probability of contamination or cross-contamination;

(f) It is held or packaged in containers composed, in whole or in part, of any poisonous or deleterious substance rendering the contents potentially injurious to health;

(g) Any substance has been substituted wholly or in part therefor;

(h) Damage or inferiority has been concealed in any manner; or

(i) Any substance has been added thereto or mixed or packaged therewith so as to increase its bulk or weight, or reduce its quality or strength, or make it appear better or of greater value than it is.

(2) "Authority" means the Oregon Health Authority.

(3) "Business day" means Monday through Friday excluding legal holidays.

(4) "Cannabinoid" means any of the chemical compounds that are the active constituents of marijuana.

(5) "Cannabinoid concentrate" means a substance obtained by separating cannabinoids from marijuana by:

(a) A mechanical extraction process;

(b) A chemical extraction process using a nonhydrocarbon-based or other solvent, such as water, vegetable glycerin, vegetable oils, animal fats, isopropyl alcohol or ethanol; or

(c) A chemical extraction process using the hydrocarbon-based solvent carbon dioxide, provided that the process does not involve the use of high heat or pressure; or

(6) "Cannabinoid edible" means food or potable liquid into which a cannabinoid concentrate, cannabinoid extract or dried marijuana leaves or flowers have been incorporated.

(7) "Cannabinoid extract" means a substance obtained by separating cannabinoids from marijuana by:

(a) A chemical extraction process using a hydrocarbon-based solvent, such as butane, hexane or propane;

(b) A chemical extraction process using the hydrocarbon-based solvent carbon dioxide, if the process uses high heat or pressure; or

(c) Any other process identified by the Commission, in consultation with the authority, by rule.

(8) Cannabinoid Product

(a) "Cannabinoid product" means a cannabinoid edible and any other product intended for human consumption or use, including a product intended to be applied to the skin or hair, that contains cannabinoids or dried marijuana leaves or flowers.

(b) "Cannabinoid product" does not include:

(A) Usable marijuana by itself;

(B) A cannabinoid concentrate by itself;

(C) A cannabinoid extract by itself; or

(D) Industrial hemp, as defined in ORS 571.300.

(9) "Cannabis Tracking System" or "CTS" means the system for tracking the transfer of marijuana items and other information as authorized by ORS 475B.150.

(10) "Compliance transaction" means a single covert, on-site visit in which a Commission authorized representative poses as an authorized representative of a licensee or a consumer and attempts to purchase or purchases a marijuana item from a licensee, or attempts to sell or sells a marijuana item to a licensee.

(11) "Container" means a sealed, hard or soft-bodied receptacle in which a marijuana item is placed prior to being sold to a consumer.

(12) "Contractor" means a person, other than a license representative, who temporarily visits the licensed premises to perform a service, maintenance or repair.

(13) "Commission" means the Oregon Liquor Control Commission.

(14) "Commissioner" means a member of the Oregon Liquor Control Commission.

(15) "Consumer" means a person who purchases, acquires, owns, holds or uses marijuana items other than for the purpose of resale.

(16) "Date of Harvest" means the date the mature marijuana plants in a harvest lot were cut, picked or removed from the soil or other growing media. If the harvest occurred on more than one day, the "date of harvest" is the day the last mature marijuana plant in the harvest lot was cut, picked or removed from the soil or other growing media.

(17) "Financial consideration" means value that is given or received either directly or indirectly through sales, barter, trade, fees, charges, dues, contributions or donations.

(18) "Financial interest" means having an interest in the business such that the performance of the business causes, or is capable of causing, an individual, or a legal entity with which the individual is affiliated, to benefit or suffer financially, and such interests include but are not limited to:

(a) Receiving, as an employee or agent, out-of-the-ordinary compensation, either in the form of overcompensation or under compensation;

(b) Lending money, real property or personal property to an applicant or licensee for use in the business at a commercially unreasonable rate;

(c) Giving money, real property or personal property to an applicant or licensee for use in the business; or

(d) Being the spouse or domestic partner of an applicant or licensee. For purposes of this subsection, "domestic partners" includes adults who qualify for a "domestic partnership" as defined under ORS 106.310.

(19) "Harvest lot" means a specifically identified quantity of marijuana that is uniform in strain, cultivated utilizing the same growing practices and harvested at the same time at the same location and cured under uniform conditions.

(20) "Immature marijuana plant" means a marijuana plant that is not flowering.

(21) "Intended for human consumption" means intended for a human to eat, drink, or otherwise put in the mouth but does not mean intended for human inhalation.

(22) "Invited guests" means family member and close associates of the licensee, not members of the general public.

(23) "Laboratory" means a laboratory certified by the Authority under ORS 438.605 to 438.620 and authorized to sample or test marijuana items for purposes specified in these rules.

(24) "Licensee" means any person who holds a license issued under ORS 475B.070, 475B.090, 475B.100, 475B.110, or 475B.560.

(25) "License holder" includes:

(a) Each applicant listed on an application that the Commission has approved;

(b) Each individual who meets the qualification described in OAR 845-025-1045 and who the Commission has added to the license under OAR 845-025-1030; or

(c) Each individual who has a financial interest in the licensed business and who the Commission has added to the license under OAR 845-025-1030.

(26) "Licensee representative" means an owner, director, officer, manager, employee, agent, or other representative of a licensee, to the extent that the person acts in a representative capacity.

(27) "Limited access area" means a building, room, or other contiguous area on a licensed premises where a marijuana item is produced, processed, stored, weighed, packaged, labeled, or sold, but does not include a point of sale area on a licensed retailer premises.

(28) "Marijuana"

(a) "Marijuana" means the plant Cannabis family Cannabaceae, any part of the plant Cannabis family Cannabaceae and the seeds of the plant Cannabis family Cannabaceae.

(b) "Marijuana" does not include industrial hemp, as defined in ORS 571.300.

(29) "Marijuana flowers" means the flowers of the plant genus Cannabis within the plant family Cannabaceae.

(30) "Marijuana items" means marijuana, cannabinoid products, cannabinoid concentrates and cannabinoid extracts.

(31) "Marijuana leaves" means the leaves of the plant genus Cannabis within the plant family Cannabaceae.

(32) "Marijuana processor" means a person who processes marijuana items in this state.

(33) "Marijuana producer" means a person who produces marijuana in this state.

(34) "Marijuana retailer" means a person who sells marijuana items to a consumer in this state.

(35) "Marijuana wholesaler" means a person who purchases marijuana items in this state for resale to a person other than a consumer.

(36) "Mature marijuana plant" means a marijuana plant that is not an immature marijuana plant.

(37) "Minor" means any person under 21 years of age.

(38) "Non-Toxic" means not causing illness, disability or death to persons who are exposed.

(39) "ORELAP" means the Oregon Environmental Laboratory Accreditation Program administered by the Authority pursuant to ORS 438.605 to 438.620.

(40) "Permittee" means any person who holds a Marijuana Workers Permit.

(41) "Person" has the meaning given that term in ORS 174.100.

(42) "Premises" or "licensed premises" includes the following areas of a location licensed under section ORS 475B.070, ORS 475B.090, ORS 475B.100, ORS 475B.110 or ORS 475B.560:

(a) All public and private enclosed areas at the location that are used in the business operated at the location, including offices, kitchens, rest rooms and storerooms;

(b) All areas outside a building that the Commission has specifically licensed for the production, processing, wholesale sale or retail sale of marijuana items; and

(c) "Premises" or "licensed premises" does not include a primary residence.

(43) "Primary Residence" means real property inhabited for the majority of a calendar year by an owner, renter or tenant, including manufactured homes and vehicles used as domiciles.

(44) "Processes"

(a) "Processes" means the processing, compounding or conversion of marijuana into cannabinoid products, cannabinoid concentrates or cannabinoid extracts;

(b) "Processes" does not include packaging or labeling.

(45) "Process lot" means:

(a) Any amount of cannabinoid concentrate or extract of the same type and processed at the same time using the same extraction methods, standard operating procedures and batches from the same harvest lot; or

(b) Any amount of cannabinoid products of the same type and processed at the same time using the same ingredients, standard operating procedures and batches from the same harvest lot or process lots of cannabinoid concentrate or extract.

(46) "Producer" means a marijuana producer licensed by the Commission.

(47) "Produces"

(a) "Produces" means the manufacture, planting, cultivation, growing or harvesting of marijuana.

(b) "Produces" does not include:

(A) The drying of marijuana by a marijuana processor, if the marijuana processor is not otherwise producing marijuana; or

(B) The cultivation and growing of an immature marijuana plant by a marijuana processor, marijuana wholesaler or marijuana retailer if the marijuana processor, marijuana wholesaler or marijuana retailer purchased or otherwise received the plant from a licensed marijuana producer.

(48) "Propagate" means to grow immature marijuana plants or to breed or produce the seeds of the plant Cannabis family Cannabaceae.

(49) "Public place" means a place to which the general public has access and includes, but is not limited to, hallways, lobbies and other parts of apartment houses and hotels not constituting rooms or apartments designed for actual residence, and highways, streets, schools, places of amusement, parks, playgrounds and areas used in connection with public passenger transportation.

(50) "Regulatory specialist" means a full-time employee of the Commission who is authorized to act as an agent of the Commission in conducting inspections or investigations, making arrests and seizures, aiding in prosecutions for offenses, issuing citations for violations and otherwise enforcing chapter 471, ORS 474.005 to 474.095 and 474.115, Commission rules and any other statutes the Commission considers related to regulating liquor or marijuana.

(51) "Retailer" means a marijuana retailer licensed by the Commission.

(52) "Safe" means:

(a) A metal receptacle with a locking mechanism capable of storing all marijuana items on a licensed premises that:

(A) Is rendered immobile by being securely anchored to a permanent structure of an enclosed area; or

(B) Weighs more than 750 pounds.

(b) A "vault"; or

(c) A refrigerator or freezer capable of being locked for storing marijuana items that require cold storage that:

(A) Is rendered immobile by being securely anchored to a permanent structure of an enclosed area; or

(B) Weighs more than 750 pounds.

(53) "Sampling laboratory" means a laboratory that only has an ORELAP accredited scope item for sampling under ORS 438.605 to 438.620 and is not accredited to perform cannabis testing.

(54) "Security plan" means a plan as described in OAR 845-025-1030(4)(f) that fully describes how an applicant will comply with applicable laws and rules regarding security.

(55) "Shipping Container" means any container or wrapping used solely for the transport of a marijuana items in bulk to a marijuana licensee as permitted in these rules.

(56) "These rules" means OAR 845-025-1000 to 845-025-8590.

(57) "UID" means unique identification.

(58)(a) "Usable Marijuana" means the dried leaves and flowers of marijuana.

(b) "Usable marijuana" does not include:

(A) The seeds, stalks and roots of marijuana; or

(B) Waste material that is a by-product of producing or processing marijuana.

(59) "Vault" means an enclosed area or room that is constructed of steel-reinforced or block concrete and has a door that contains a multiple-position combination lock or the equivalent, a relocking device or equivalent, and a steel plate with a thickness of at least one-half inch.

(60) "Wholesaler" means a marijuana wholesaler licensed by the Commission.

Stat. Auth.: ORS 475B.025

Stats. Implemented: ORS 475B.015 & 475B.025

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1030

Application Process

(1) A person may submit an application to the Commission, on a form prescribed by the Commission, for a marijuana producer, processor, wholesaler, retail, or laboratory license.

(2) An application for a license and all documentation required in the application instructions and in section (4) of this rule must be submitted in a manner specified by the Commission. The application fee specified in OAR 845-025-1060 must also be paid in a manner specified by the Commission.

(3) An application must include the names and other required information for all individuals who are applicants as described in OAR 845-025-1045 and who are not applicants but who have a "financial interest" in the business, as defined in OAR 845-025-1015.

(4) In addition to submitting the application form the following must be submitted:

(a) For an individual listed as an applicant:

(A) Information or fingerprints for a criminal background check in accordance with OAR 845-025-1080;

(B) Any forms required by the Commission and any information identified in the form that is required to be submitted; and

(C) Proof of residency documented by providing:

(i) Oregon full-year resident tax returns for the last two years; or

(ii) Utility bills, rental receipts, mortgage statements or similar documents that contain the name and address of the applicant dated at least two years prior to the date of application and from the most recent month.

(b) For an individual listed as a person with a financial interest who holds or controls an interest of ten percent or greater in the business proposed to be licensed, or an individual who is a partner, member or corporate officer of a legal entity with a financial interest in the business proposed to be licensed:

(A) Information or fingerprints for a criminal background check in accordance with OAR 845-025-1080;

(B) Any forms required by the Commission and any information identified in the form that is required to be submitted; and

(c) A map or sketch of the premises proposed for licensure, including the defined boundaries of the premises and the location of any primary residence located on the same lot or parcel as the licensed premises;

(d) A scaled floor or plot plan sketch of all enclosed areas with clear identification of walls, partitions, counters, windows, all areas of ingress and egress, and all limited access areas;

(e) Proof of right to occupy the premises proposed for licensure;

(f) An operating plan that demonstrates at a minimum, how the applicant's proposed premises and business will comply with the applicable laws and rules regarding:

(A) Security;

(B) Employee qualifications and training;

(C) Transportation of product;

(D) Preventing minors from entering the licensed premises; and

(E) Preventing minors from obtaining or attempting to obtain marijuana items.

(g) For producers:

(A) The proposed canopy size and tier as described in OAR 845-025-2040 and a designation of the canopy area within the license premises.

(B) A report describing the applicant's electricity and water usage, on a form prescribed by the Commission.

(i) For initial licensure and renewal, the report must describe the estimated electricity and water usage taking into account all portions of the premises and expected requirements of the operation for the next twelve months.

(ii) In addition to requirements of section (4)(g)(B)(i), for renewal, the report must describe the actual electricity and water usage for the previous year taking into account all portions of the premises.

(C) A description of the growing operation including growing media, a description of equipment to be used in the production, and whether production will be indoor, outdoor or both.

(D) Proof of a legal source of water as evidenced by:

(i) A copy of a water right permit, certificate, or other water use authorization from the Oregon Water Resources Department;

(ii) A statement that water is supplied from a public or private water provider, along with the name and contact information of the water provider; or

(iii) Proof from the Oregon Water Resources Department that the water to be used for production is from a source that does not require a water right.

(h) For processors:

(A) On a form prescribed by the Commission, the proposed endorsements as described in OAR 845-025-3210.

(B) A description of the type of products to be processed, a description of equipment to be used, including any solvents, gases, chemicals or other compounds used to create extracts or concentrates.

(5) In addition to submitting the application form and the items described in (4) of this rule the Commission may require the following to be submitted:

(a) For an individual identified as a person with a financial interest, who holds or controls an interest of less than ten percent in the business proposed to be licensed:

(A) Information or fingerprints for a criminal background check in accordance with OAR 845-025-1080;

(B) Any forms required by the Commission and any information identified in the form that is required to be submitted; and

(b) Any additional information if there is a reason to believe that the information is needed to determine the merits of the license application.

(6) The Commission must review an application to determine if it is complete. An application will be considered incomplete if an application form is not complete, the full application fee has not been paid, or some or all of the additional information required under sections (4) and (5) of this rule is not submitted.

(7) An applicant may submit a written request for reconsideration of a decision that an application is incomplete. Such a request must be received by the Commission within ten days of the date the incomplete notice was mailed to the applicant. The Commission shall give the applicants the opportunity to be heard if an application is rejected. A hearing under this subsection is not subject to the requirements for contested case proceedings under ORS 183.310 to 183.550.

(8) If, prior to an application being acted upon by the Commission, there is a change with regard to who is an applicant or who is a person with a financial interest in the proposed business, the new applicant or person with a financial interest must submit a form, prescribed by the Commission, that:

(a) Identifies the individual or person;

(b) Describes the individual's or person's financial interest in the business proposed for licensure; and

(c) Includes any additional information required by the Commission, including but not limited to information and fingerprints required for a criminal background check.

(9) Failure to comply with subsection (6) of this rule may result in an application being denied.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.040, 475B.045, 475B.060, 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1045
Qualifications of an Applicant

(1) The following are considered applicants for purposes of these rules:

(a) Any individual that has a financial interest in the business for which licensure is sought and who is directly involved in controlling the ordinary course of business for the business that is proposed to be licensed; and

(b) Any legal entity that has a financial interest in the business for which licensure is sought and is directly involved in controlling the ordinary course of business for the business that is proposed to be licensed;

(2) If an applicant is an individual the individual must also:

(a) Be at least 21 years of age; and

(b) Until January 1, 2020, have been a resident of Oregon for at least two consecutive years prior to the date the initial or renewal application was submitted.

(3) If a legal entity is designated as an applicant, the following individuals must also be listed as applicants on an application:

(a) All partners in a limited partnership;

(b) All members of a limited liability company; and

(c) All directors and principal officers of a corporate entity.

(d) Any individual who owns or controls at least 10% of the legal entity.

(4) At least one applicant or the sum of applicants listed on a license application must be a legitimate owner of the business proposed to be licensed or subject to renewal.

(5) An individual or legal entity will not be considered by the Commission to be directly involved in the ordinary course of business for the business proposed to be licensed solely by virtue of:

(a) Being a shareholder, director, member or limited partner;

(b) Being an employee or independent contractor; or

(c) Participating in matters that are not in the ordinary course of business such as amending organizational documents of the business entity, making distributions, changing the entity's corporate structure, or approving transactions outside of the ordinary course of business as specified in the entity's organizational documents.

(6) An applicant will be considered by the Commission to be a legitimate owner of the business if:

(a) The individual applicant or legal entity applicant owns at least 51% of the business proposed to be licensed; or

(b) One or more individual applicants in sum own at least 51% of the business proposed to be licensed.

(7) The following factors, in and of themselves, do not constitute ownership:

(a) Preferential rights to distributions based on return of capital contribution;

(b) Options to purchase an ownership interest that may be exercised in the future;

(c) Convertible promissory notes; or

(d) Security interests in an ownership interest.

(8) For purposes of this rule, "ownership" means direct or indirect ownership of the shares, membership interests, or other ownership interests of the business proposed to be licensed.

(9) The Commission may consider factors other than those listed in this rule when determining whether an individual or legal entity is directly involved in the operation or management of the business proposed to be licensed or licensed, or is a legitimate owner.

(10) An individual listed as an applicant on an initial or renewal application, or identified by the Commission as an applicant must maintain Oregon residency while the business is licensed.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.045, 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1060
Fees

(1) At the time of initial license or certificate application an applicant must pay a $250 non-refundable application fee.

(2) If the Commission approves an application and grants an annual license, the following fees must be paid, prorated for an initial license that is issued for six months or less:

(a) Producers:

(A) Tier I $3,750;

(B) Tier II $5,750.

(b) Processors: $4,750;

(c) Wholesalers: $4,750;

(d) Retailers: $4,750;

(e) Laboratories: $4,750.

(3) At the time of license or certificate application renewal, an applicant must pay a $250 non-refundable application fee. If the Commission approves an application and grants a research certificate, the fee shall be $4,750 for a three-year term.

(4) If the Commission approves a renewal application the renewal license or certificate fees must be paid in the amounts specified in subsections (2) and (3) of this rule.

(5) If the Commission approves an initial or renewal application and grants a marijuana handler permit, the individual must pay a $100 permit fee.

(6) The Commission shall charge the following fees:

(a) Criminal background checks: $50 per individual (if the background check is not part of an initial or renewal application).

(b) Change of ownership review: $1000 per license.

(c) Change in business structure review: $1000 per license.

(d) Transfer of location of premises review: $1000 per license.

(e) Packaging preapproval: $100.

(f) Labeling preapproval: $100.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110, 475B.218, 475B.560, 475B.610 & 475B.620
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1070
Late Renewal Fees

(1) If the Commission receives a completed license or certificate renewal application less than 20 days before the date the existing license or certificate expires, the Commission will charge a late renewal fee of $150 for licenses and certificates.

(2) If the Commission receives a completed license or certificate renewal application within 30 days after the date the existing license or certificate expires, the Commission will charge a late renewal fee equal to $300 for licenses and certificates.

Stat. Auth.: ORS 475B.025

Stats. Implemented: ORS 475B.025
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1080
Criminal Background Checks

(1) If an individual is required by the Commission to undergo a criminal background check, the individual must provide to the Commission:

(a) A criminal background check request form, prescribed by the Commission that includes but is not limited to:

(A) First, middle and last name;

(B) Any aliases;

(C) Date of birth;

(D) Driver's license information; and

(E) Address and recent residency information.

(b) Fingerprints in accordance with the instructions on the Commission's webpage.

(2) The Commission may request that an applicant disclose his or her Social Security Number if notice is provided that:

(a) Indicates the disclosure of the Social Security Number is voluntary; and

(b) That the Commission requests the Social Security Number for the purpose of positively identifying the applicant during the criminal records check process.

(3) An applicant's criminal history must be evaluated by the Commission in accordance with ORS 670.280 and 475B.050.

(4) The Commission may conduct a criminal background checks in accordance with this rule every year at the time of application renewal.

(5) Records concerning criminal background checks must be kept and handled by the Commission in accordance with ORS 181.534(15).

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.050
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1090
Application Review

(1) Once the Commission has determined that an application is complete it must review the application to determine compliance with ORS Chapter 475B and these rules.

(2) The Commission:

(a) Must, prior to acting on an application, request a land use compatibility statement from the city or county that authorizes land use in the city or county in which the applicant's proposed premises is located; or request verification that a land use compatibility statement submitted by an applicant is valid and accurate.

(b) May, in its discretion, prior to acting on an application:

(A) Contact any applicant or individual with a financial interest and request additional documentation or information; and

(B) Verify any information submitted by the applicant.

(3) The Commission must inspect the proposed premises prior to issuing a license.

(4) If during an inspection the Commission determines the applicant is not in compliance with these rules, the applicant will be provided with a notice of the failed inspection and the requirements that have not been met.

(a) An applicant that fails an inspection will have 15 calendar days from the date the notice was sent to submit a written response that demonstrates the deficiencies have been corrected.

(b) An applicant may request in writing one extension of the 15-day time limit in subsection (a) of this section, not to exceed 30 days.

(5) If an applicant does not submit a timely plan of correction or if the plan of correction does not correct the deficiencies in a manner that would bring the applicant into compliance, the Commission may deny the application.

(6) If the plan of correction appears, on its face, to correct the deficiencies, the Commission will schedule another inspection.

(7) If an applicant fails a second inspection, the Commission may deny the application unless the applicant shows good cause for the Commission to perform additional inspections.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.045, 475B.063 & 475B.285
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1100
Approval of Application and Issuance of License

(1) If, after the application review and inspection, the Commission determines that an applicant is in compliance with ORS 475B.025 to 475B.235 and these rules the Commission must notify the applicant in writing that the application has been approved and after payment by the applicant of the license fee, provide the applicant with proof of licensure that includes a unique license number, the effective date of the license, date of expiration, and a description of premises for which the license was issued. If the applicant paid the license fee with a check the Commission will not issue a license until it has confirmation that the check has cleared.

(2) A licensee:

(a) May not operate until on or after the effective date of the license.

(b) Must display proof of licensure in a prominent place on the premises.

(c) May not use the Commission name or logo on any signs at the premises, on the business' website, or in any advertising or social media, except to the extent that information is contained on the proof of licensure.

(3) Licensure is only valid for the premises indicated on the license and is only issued to the individuals or entities listed on the application or subsequently approved by the Commission.

(4) A license may not be transferred except as provided in OAR 845-025-1160.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.055
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1115
Denial of Application

(1) The Commission must deny an initial or renewal application if:

(a) An applicant is under the age of 21 or, until January 1, 2020, has not been a resident or Oregon for at least two years. If the Commission determines that an applicant is a non-resident the Commission will hold that application under review until 30 days after the 2016 Oregon Legislature adjourns.

(b) The applicant's land use compatibility statement shows that the proposed land use is prohibited in the applicable zone, if a land use compatibility statement is required.

(c) The proposed licensed premises is located:

(A) On federal property.

(B) On reservation or tribal trust land of a federally recognized Indian tribe unless that tribe has entered into an agreement with the State of Oregon which allows licensing of recreational marijuana businesses. Any license issued on tribal lands is subject to the same requirements as a license issued on non-tribal land.

(d) The proposed licensed premises of a producer applicant who has applied to produce marijuana outdoors is:

(A) On public land; or

(B) On the same lot or parcel, as defined in ORS 92.010, as another producer licensee; or under common ownership; or

(C) On the same lot or parcel, as defined in ORS 92.010, as a retail, processor or wholesale license, unless all of the licenses on the lot or parcel are held or sought by the same applicant.

(e) The proposed licensed premises of a producer applicant who has applied to produce marijuana indoors is on the same lot or parcel, as defined in ORS 92.010, as another producer licensee under common ownership.

(f) The proposed licensed premises of a producer is located on the same lot or parcel, as those terms are defined in ORS 92.010, as a site registered with Oregon Department of Agriculture for the production of industrial hemp, unless the applicant submits and the Commission approves a control plan describing how the registered site will be separated from the premises proposed to be licensed and how the applicant will prevent transfer of industrial hemp to the licensed premises.

(g) The proposed licensed premises of a processor who has applied for an endorsement to process extracts is located in an area that is zoned exclusively for residential use.

(h) The proposed licensed premises of a retail applicant is located:

(A) Within 1,000 feet of:

(i) A public elementary or secondary school for which attendance is compulsory under ORS 339.020; or

(ii) A private or parochial elementary or secondary school, teaching children as described in ORS 339.030.

(B) In an area that is zoned exclusively for residential use.

(i) The proposed licensed premises of a wholesaler applicant is in an area zoned exclusively for residential use.

(j) A city or county has prohibited the license type for which the applicant is applying, in accordance with ORS 475B.800.

(2) The Commission may deny an initial or renewal application, unless the applicant shows good cause to overcome the denial criteria, if it has reasonable cause to believe that:

(a) The applicant:

(A) Is in the habit of using alcoholic beverages, habit-forming drugs, marijuana, or controlled substances to excess.

(B) Has made false statements to the Commission.

(C) Is incompetent or physically unable to carry on the management of the establishment proposed to be licensed.

(D) Is not of good repute and moral character.

(E) Does not have a good record of compliance with ORS 475B.010 to 475B.395, or these rules, prior to or after licensure including but not limited to:

(i) The giving away of marijuana items as a prize, premium or consideration for a lottery, contest, game of chance or skill, or competition of any kind, in violation of ORS 475B.275;

(ii) Providing marijuana items to an individual without checking that the individual is 21 or older;

(iii) Unlicensed transfer of marijuana items for financial consideration; or

(iv) Violations of local ordinances adopted under ORS 475B.340, pending or adjudicated by the local government that adopted the ordinance.

(F) Is not possessed of or has not demonstrated financial responsibility sufficient to adequately meet the requirements of the business proposed to be licensed.

(G) Is unable to understand the laws of this state relating to marijuana or these rules, including but not limited to ORS 475.300 to 475.346 and ORS 475B.550 to 475B.590. Inability to understand laws and rules of this state related to marijuana may be demonstrated by violations documented by the Oregon Health Authority.

(b) Any individual listed on the application has been convicted of violating a general or local law of this state or another state, or of violating a federal law, if the conviction is substantially related to the fitness and ability of the applicant to lawfully carry out activities under the license, except as specified in ORS 475B.045(3).

(c) Any applicant is not the legitimate owner of the business proposed to be licensed, or other persons have an ownership interest in the business have not been disclosed to the Commission.

(d) The business proposed to be licensed is located at the same physical location or address as a premises licensed under ORS Chapter 471 or as a retail liquor agent appointed by the Commission.

(3) The Commission may refuse to issue a license to any license applicant or refuse to renew the license of any licensee when conditions exist in relation to any person having a financial interest in the business or in the place of business which would constitute grounds for refusing to issue a license or for revocation or suspension of a license if such person were the license applicant or licensee.

(4)(a) The Commission may deny any initial or renewal application and may revoke any license if medical marijuana items are produced, processed, stored, sold or transported, to or from the same address or location of licensed business or business proposed to be licensed.

(b) The Commission will not deny an initial application under this subsection if:

(A)The applicant surrenders any registration issued by the Authority for the address or location of the business proposed to be licensed;

(B) If applicable, the applicant notifies all other growers registered by the Authority at the location or address proposed to be licensed, in a form and manner prescribed by the Commission, that the grower is no longer permitted to produce medical marijuana at the address or location proposed to be licensed and must surrender his or her registration at that address or location; and

(C) All medical marijuana activity at the location or address proposed to be licensed ceases prior to being issued an OLCC license.

(5) If the Commission denies an application because an applicant submitted false or misleading information to the Commission, the Commission may prohibit the applicant from re-applying for five years.

(6) A notice of denial must be issued in accordance with ORS 183.

Stat. Auth.: ORS 475B.025

Stats. Implemented: ORS 475B.040, 475B.045, 475B.070, 475B.090, 475B.100, 475B.110, 475B.063, 475B.560 &475B.800

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2015(Temp), f. 12-22-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1130

Withdrawal of Application

An applicant may withdraw an initial or renewal application at any time prior to the Commission acting on the application unless the Commission has determined that the applicant submitted false or misleading information in which case the Commission may refuse to accept the withdrawal and may issue a notice of proposed denial in accordance with OAR 845-025-1115.

Stat. Auth.: ORS 475B.025

Stats. Implemented: ORS 475B.045

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1145

Communication With Commission

(1) If an applicant or licensee is required to or elects to submit anything in writing to the Commission, unless otherwise prescribed by the Commission, the applicant or licensee may submit the writing to the Commission via:

(a) Mail;

(b) In-person delivery;

(c) Facsimile; or

(d) E-mail.

(2) If a written notification must be submitted by a particular deadline it must be received, regardless of the method used to submit the writing, by 5:00 p.m. Pacific Time.

Stat. Auth.: ORS 475B.025

Stats. Implemented: ORS 475B.025

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1160

Notification of Changes

(1) An applicant or licensee must notify the Commission in writing within 10 calendar days of any of the following:

(a) A change in any contact information for anyone listed in an application or subsequently identified as an applicant or an individual with a financial interest;

(b) The arrest or conviction for any misdemeanor or felony of an individual listed in an application or subsequently identified as an applicant, licensee or individual with a financial interest;

(c) A disciplinary proceeding or licensing enforcement action by another governmental entity that may affect the licensee's business;

(d) The filing of bankruptcy;

(e) The closure of bank accounts or credit cards by a financial institution;

(f) The temporary closure of the business for longer than 30 days; or

(g) The permanent closure of the business.

(2) An applicant or licensee must notify the Commission in a manner prescribed by the Commission within 24 hours of the arrest or conviction for any misdemeanor or felony of an individual listed in an application or subsequently identified as an applicant, licensee or individual with a financial interest.

(3) A licensee must notify the Commission as soon as reasonably practical and in no case more than 24 hours from the theft of marijuana items or money from the licensed premises.

(4) Changes in Financial Interest or Business Structure. A licensee that proposes to change its corporate structure, ownership structure or change who has a financial interest in the business must submit a form prescribed by the Commission, and any information identified in the form to be submitted, to the Commission, prior to making such a change.

(a) The Commission must review the form and other information submitted under subsection (1) of this rule, and will approve the change if the change would not result in an initial or renewal application denial under OAR 845-025-1115, or serve as the basis of a license suspension or revocation.

(b) If the Commission denies the change but the licensee proceeds with the change the licensee must surrender the license or the Commission will propose to suspend or revoke the license.

(c) The Commission will not accept a form for a change in corporate structure or financial interest if the license is expiring in less than 90 days, the licensee is under investigation by the Commission, or has been issued a Notice by the Commission following an alleged violation and the alleged violation has not been resolved.

(d) If a licensee has a change in ownership that is 51% or greater, a new application must be submitted in accordance with OAR 845-025-1030.

(5) Change of Location.

(a) A licensee who wishes to change the location of the licensed premises must submit a completed application for the new premises including all required forms and documents and the fee specified in OAR 845-025-1060, but does not need to submit information and fingerprints required for a

criminal background check if there are no changes to the individuals listed on the initial application.

(b) The Commission must approve any change of location prior to licensee beginning business operations in the new location.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.055 & 475B.045
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1175
Changing, Altering, or Modifying Licensed Premises

(1) A licensee may not make any physical changes to the licensed premises that materially or substantially alter the licensed premises or the usage of the licensed premises from the plans originally approved by the Commission without the Commission's prior written approval.

(2) A licensee who intends to make any material or substantial changes to the licensed premises must submit a form prescribed by the Commission, and submit any information identified in the form to be submitted, to the Commission, prior to making any such changes.

(3) The Commission must review the form and other information submitted under subsection (2) of this rule, and will approve the changes if the changes would not result in an initial or renewal application denial under OAR 845-025-1115.

(4) If the Commission denies the change the licensee must not make the proposed changes. If the licensee makes the proposed changes, the licensee must surrender the license or the Commission will propose to suspend or revoke the license.

(5) For purposes of this rule a material or substantial change requiring approval includes, but is not limited to:

(a) Any increase or decrease in the total physical size or capacity of the licensed premises;

(b) The sealing off, creation of or relocation of a common entryway, doorway, passage or other such means of public ingress or egress, when such common entryway, doorway or passage alters or changes limited access areas, such as the areas in which cultivation, harvesting, processing, or sale of marijuana items occurs within the licensed premises; or

(c) Any physical change that would require the installation of additional video surveillance cameras or a change in the security system.

(d) Any addition or change of location of a primary residence located on the same tax lot or parcel as a licensed premises.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1190
License Renewal

(1) Renewal Applications:

(a) Any licensee who files a completed renewal application with the Commission at least 20 days before the date the license expires may continue to operate as if the license were renewed, pending a decision by the Commission;

(b) Any licensee who does not file a completed renewal application at least 20 days before the existing license expires must stop engaging in any licensed activity when the license expires. However:

(A) If the Commission receives a completed license renewal application less than 20 days before the date the existing license expires, the Commission will, upon receipt of the appropriate late renewal fee in OAR 845-025-1070, issue a letter of authority to operate beyond the expiration of the license, pending a decision by the Commission;

(B) A licensee must not engage in any licensed activity after the license expires. If the Commission receives a completed license renewal application within 30 days after the date the existing license expires, the Commission will, upon receipt of the appropriate late renewal fee in OAR 845-025-1070, issue a letter of authority to resume operation, pending a decision by the Commission.

(c) The Commission will not renew a license if the Commission receives the renewal application more than 30 days after the license expires. A person who wants to resume licensed activity in this circumstance:

(A) Must submit a completed new application, including the documents and information required by the Commission; and

(B) Must not engage in any licensed activity unless and until they receive authority to operate from the Commission after submitting the completed new application.

(d) A person relicensed under section (1)(c) of this rule who engaged in any activity that would require a license while not licensed in violation of section (1)(b)(B) of this rule may be subject to administrative and criminal sanctions.

(e) A person who engages in any activity that requires a license but is not licensed may be subject to criminal prosecution.

(f) For purposes of this rule, a completed application:

(A) Is considered filed when received by the Commission; and

(B) Is one that is completely filled out, is signed by all applicants and includes the appropriate fee.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Stats. Implemented: ORS 475B.040
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1200
Financial and Business Records

In addition to any other recordkeeping requirements in these rules, a marijuana licensee must have and maintain records that clearly reflect all financial transactions and the financial condition of the business. The following records may be kept in either paper or electronic form and must be maintained for a three-year period and must be made available for inspection if requested by an employee of the Commission:

(1) Purchase invoices and supporting documents for items and services purchased for use in the production, processing, research, testing and sale of marijuana items that include from whom the items were purchased and the date of purchase;

(2) Bank statements for any accounts relating to the licensed business;

(3) Accounting and tax records related to the licensed business;

(4) Documentation of all financial transactions related to the licensed business, including contracts and agreements for services performed or received that relate to the licensed business; and

(5) All employee records, including training.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.130
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1215
Standardized Scales

(1) A licensee shall use an Oregon Department of Agriculture licensed weighing device as defined in ORS chapter 618 and OAR 603, Division 27:

(a) Whenever marijuana items are bought and sold by weight;

(b) Whenever marijuana items are packaged for sale by weight;

(c) Whenever marijuana items are weighed for entry into CTS; and,

(d) Whenever the weighing device is used commercially as defined in ORS 618.010.

(2) Notwithstanding the requirements in sections (1) of this rule a laboratory licensee may utilize any scale permitted by ORELAP under OAR 333, Division 64.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1230
Licensed Premises Restrictions and Requirements

(1) A licensed premises may not be located:

(a) On federal property; or

(b) At the same physical location or address as a:

(A) Medical marijuana grow site registered under ORS 475.304, unless the grow site is also licensed under ORS 475B.080;

(B) Medical marijuana processing site registered under ORS 475B.435; or

(C) Medical marijuana dispensary registered under ORS 475B.450.

(D) Liquor licensee licensed under ORS Chapter 471 or as a retail liquor agent appointed by the Commission.

(2) The licensed premises of a producer applicant may not be on:

(a) Public land; or

(b) The same tax lot or parcel as another producer licensee under common ownership.

(3) The licensed premises of a retailer may not be located:

(a) Within 1,000 feet of:

(A) A public elementary or secondary school for which attendance is compulsory under ORS 339.020; or

(B) A private or parochial elementary or secondary school, teaching children as described in ORS 339.030.

(b) In an area that is zoned exclusively for residential use.

(4) The licensed premises of a processor who has an endorsement to process extracts may not be located in an area that is zoned exclusively for residential use.

(5) The licensed premises of a processor, wholesaler, laboratory and retailer must be enclosed on all sides by permanent walls and doors.

(6) A licensee may not permit:

(a) Any minor on a licensed premises except as described in section (7) and (8) of this rule; or

(b) On-site consumption of a marijuana item, alcohol, or other intoxicant by any individual, except that a license representative who has a current registry identification card issued under ORS 475B.415 may consume marijuana during his or her work shift on the licensed premises as necessary for his or her medical condition, if the employee is alone, in a closed room and not visible to others outside the room. A license representative who consumes a marijuana item as permitted under this section may not be intoxicated while on duty. For purposes of this section allowable on-site consumption in an enclosed area, as that as defined in OAR 333-015-0030 does not include smoking, combusting, inhaling, vaporizing, or aerosolizing a marijuana item.

(7) Notwithstanding section (6)(a) of this rule, a minor, other than a licensee's employee, who has a legitimate business purpose for being on the licensed premises, may be on the premises for a limited period of time in order to accomplish the legitimate business purpose. For example, a minor plumber may be on the premises in order to make a repair.

(8) Notwithstanding section (6)(a) of this rule, a minor who resides on the tax lot or parcel where a marijuana producer is licensed may be present on those portions of a producer's licensed that do not contain usable marijuana or cut and drying marijuana plants.

(9) A licensee must clearly identify all limited access areas in accordance with OAR 845-025-1245.

(10) A licensee must keep a daily log of all employees, contractors and license representatives who perform work on the licensed premises. All employees, contractors and licensee representatives present on the licensed premises must wear clothing or a badge issued by the licensee that easily identifies the individual as an employee, contractor or licensee representative.

(a) A licensee must record the name and permit number of every current employee and license representative in CTS.

(b) If a current employee or license representative is not required to have a marijuana worker permit, the licensee must record the name and date of birth for that individual in CTS.

(c) A licensee must record the name and date of birth for every contractor who performs work on the licensed premises. If the contractor is licensed by the State of Oregon, the licensee must also record the contractor's license number.

(11) The general public is not permitted in limited access areas on a licensed premises, except for the consumer sales area of a retailer and as provided by section (14) of this rule. In addition to licensee representatives, the following visitors are permitted to be present in limited access areas on a licensed premises, subject to the requirements in section (12) and (13) of this rule:

(a) Laboratory personnel, if the laboratory is licensed by the Commission;

(b) A contractor, vendor or service provider authorized by a licensee representative to be on the licensed premises;

(c) Another licensee or that licensee's representative;

(d) Invited guests as defined in OAR 845-025-1015 subject to requirements of section (12) of this rule; or

(e) Tour groups as permitted under section (14) of this rule.

(12) Prior to entering a licensed premises all visitors permitted by section (11) of this rule must be documented and issued a visitor identification badge from a licensee representative that must remain visible while on the licensed premises. A visitor badge is not required for government officials. All visitors described in subsection (11) of this rule must be accompanied by a licensee representative at all times.

(13) A licensee must maintain a log of all visitor activity allowed under section (11) of this rule. The log must contain the first and last name and date of birth of every visitor and the date they visited. A licensee is not required to record the date of birth for government officials.

(14) A marijuana producer or research certificate holder may offer tours of the licensed premises, including limited access areas, to the general public if the licensee submits a control plan in writing and the plan is approved by the Commission.

(a) The plan must describe how conduct of the individuals on the tour will be monitored, how access to usable marijuana will be limited, and what steps the licensee will take to ensure that no minors are permitted on the licensed premises.

(b) The Commission may withdraw approval of the control plan if the Commission finds there is poor compliance with the plan. Poor compliance may be indicated by, for example, individuals on the tour not being adequately supervised, an individual on the tour obtaining a marijuana item while on the tour, a minor being part of a tour, or the tours creating a public nuisance.

(15) Nothing in this rule is intended to prevent or prohibit Commission employees or contractors, or other state or local government officials that have jurisdiction over some aspect of the licensed premises or licensee from being on the licensed premises.

(16) A licensee may not sublet any portion of a licensed premises.

(17) A licensed premises may receive marijuana items only from a marijuana producer, marijuana processor, or marijuana wholesaler for whom a premises has been licensed by the Commission.

(18) A licensed wholesaler or retailer who sells or handles food, as that term is defined in ORS 616.695, or cannabinoid edibles must also be licensed by the Oregon Department of Agriculture under ORS 616.706.

(19) Notwithstanding section (6)(a) of this rule, a minor may pass through the licensed area of an outdoor producer in order to reach an unlicensed area, so long as the minor is not present in areas that contain marijuana items.

Stat. Auth.: ORS 475B.025, ORS 475B.070, ORS 475B.090, ORS 475B.100, ORS 475B.110
Stats. Implemented: ORS 475B.090, 475B.100, 475B.110, 475B.260, 475B.005, 475B.180 & 475B.280
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1245
Signage

(1) A licensee must post:

(a) At every licensed premises signs that read:

(A) "No Minors Permitted Anywhere on This Premises"; and

(B) "No On-Site Consumption of Marijuana"; and

(b) At all areas of ingress or egress to a limited access area a sign that reads: "Do Not Enter – Limited Access Area – Access Limited to Licensed Personnel and Escorted Visitors."

(2) All signs required by this rule must be:

(a) Legible, not less than 12 inches wide and 12 inches long, composed of letters not less than one-half inch in height;

(b) In English and Spanish; and

(c) Posted in a conspicuous location where the signs can be easily read by individuals on the licenses premises.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.260
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1260
Standards for Authority to Operate a Licensed Business as a Trustee, a Receiver, a Personal Representative or a Secured Party

(1) The Commission may issue a temporary authority to operate a licensed business to a trustee, the receiver of an insolvent or bankrupt licensed business, the personal representative of a deceased licensee, or a person holding a security interest in the business for a reasonable period of time to allow orderly disposition of the business.

(a) The trustee, receiver or personal representative must provide the Commission with the following information:

(A) Proof that the person is the legal trustee, receiver or personal representative for the business; and

(B) A written request for authority to operate as a trustee, receiver or personal representative, listing the address and telephone number of the trustee, receiver or personal representative.

(b) The secured party must provide the Commission with the following information:

(A) Proof of a security interest in the licensed business;

(B) Proof of the licensee's default on the secured debt;

(C) Proof of legal access to the real property; and

(D) A written request for authority to operate as a secured party listing the secured party's address and telephone number.

(2) The Commission may revoke or refuse to issue or extend authority for the trustee, receiver, personal representative, or secured party to operate:

(a) If the trustee, receiver, personal representative or secured party does not propose to operate the business immediately or does not begin to operate the business immediately upon receiving the temporary authority;

(b) For any of the reasons that the Commission may revoke or refuse to issue or renew a license;

(c) If the trustee, receiver, personal representative or secured party operates the business in violation of ORS 475B, or these rules; or

(d) If a reasonable time for disposition of the business has elapsed.

(3) No person or entity described in section (1) of this rule may operate the business until a certificate of authority has been issued under this rule, except that the personal representative of a deceased licensee may operate the business for up to 10 days after the death provided that the personal representative submits the information required in section (1)(a) of this rule and obtains a certificate of authority within that time period.

(4) A certificate of authority under this rule is initially issued for a 60-day period and may be extended as reasonably necessary to allow for the disposition of the business.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.033
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1275
Closure of Business

(1) A license expires upon death of a licensee unless the Commission issues an order as described in subsection (2) of this rule.

(2) The Commission may issue an order providing for the manner and condition under which:

(a) Marijuana items left by a deceased, insolvent or bankrupt person or licensee, or subject to a security interest, may be foreclosed, sold under execution or otherwise disposed.

(b) The business of a deceased, insolvent or bankrupt licensee may be operated for a reasonable period following the death, insolvency or bankruptcy.

(3) A secured party, as defined in ORS 79.0102, may continue to operate a business for which a license has been issued under section ORS 475B.070, 475B.090, 475B.100 or 475B.110 for a reasonable period after default on the indebtedness by the debtor.

(4) If a license is revoked the Commission must address in its order the manner and condition under which marijuana items held by the licensee may be transferred or sold to other licensees or must be otherwise disposed.

(5) If a license is surrendered or expires the Commission may address by order the manner and condition under which marijuana items held by the licensee may be transferred or sold to other licensees or must be otherwise disposed of.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.033
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1290
Licensee Responsibility

A licensee is responsible for:

(1) The violation of any administrative rule of the Commission; any provision of ORS chapter 475B affecting the licensee's license privileges.

(2) Any act or omission of a licensee representative in violation of any administrative rule of the Commission or any provision of ORS chapter 475B affecting the licensee's license privileges.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1295
Local Ordinances

The Commission may impose a civil penalty, suspend or revoke any license for failure to comply with an ordinance adopted by a city or county pursuant ORS 475B.340 if the city or county:

(1) Has provided the licensee with due process substantially similar to the due process provided to a licensee under the Administrative Procedures Act, ORS 183.413 to 183.470; and

(2) Provides the Commission with a final order that is substantially similar to the requirements for a final order under ORS 183.470 that establishes that the licensee has violated the local ordinance.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, & 475B.110
Stats. Implemented: ORS 475B.340
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1300
Licensee Prohibitions

(1) A licensee may not:

(a) Import into this state or export from this state any marijuana items;

(b) Give marijuana items as a prize, premium or consideration for a lottery, contest, game of chance or game of skill, or competition of any kind;

(c) Sell, give or otherwise make available any marijuana items to any person who is visibly intoxicated;

(d) Make false representations or statements to the Commission in order to induce or prevent action by the Commission;

(e) Maintain a noisy, disorderly or insanitary establishment or supply adulterated marijuana items;

(f) Misrepresent any marijuana item to a customer or to the public;

(g) Sell any marijuana item through a drive-up window;

(h) Deliver marijuana to any consumer off the licensed premises except as permitted by OAR 845-025-2880;

(i) Sell or offer to sell a marijuana item that does not comply with the minimum standards prescribed by the statutory laws of this state; or

(j) Use or allow the use of a mark or label on the container of a marijuana item that is kept for sale if the container does not precisely and clearly indicate the nature of the container's contents or in any way might deceive a customer as to the nature, composition, quantity, age or quality of the marijuana item.

(2) No licensee or licensee representative may be under the influence of intoxicants while on duty.

(a) For purposes of this rule "on duty" means:

(A) The beginning of a work shift that involves the handling or sale of marijuana items, checking identification or controlling conduct on the licensed premises, to the end of the shift including all breaks;

(B) For an individual working outside a scheduled work shift, the performance of acts on behalf of the licensee that involve the handling or sale of marijuana items, checking identification or controlling conduct on the licensed premises, if the individual has the authority to put himself or herself on duty; or

(C) A work shift that includes supervising those who handle or sell marijuana items, check identification or control the licensed premises.

(b) Whether a person is paid or scheduled for work is not determinative of whether the person is considered "on duty" under this subsection.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110
Stats. Implemented: ORS 475B.185, 475B.190, 475B.195, 475B.205, 475B.270 & 475B.275
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1330
Trade Samples

(1) The following licensees may provide samples of marijuana items to other licensees for the purpose of determining whether to purchase the product:

(a) A producer may provide a sample of usable marijuana to a marijuana wholesaler, retailer or processor licensee.

(b) A processor may provide a sample of a cannabinoid product, concentrate or extract to a marijuana wholesaler or retailer.

(c) A wholesaler may provide a sample of usable marijuana or a cannabinoid product, concentrate or extract to a marijuana wholesaler, retailer or processor licensee.

(2) The sample marijuana items may not be consumed or used on a licensed premises.

(3) The sample may not be resold to another licensee or consumer.

(4) Any sample provided to another licensee or received by a licensee must be recorded in CTS.

(5) Any samples provided under this rule must be tested in accordance with OAR 333-007-0300 to 333-007-0490.

(6) A licensee is limited to providing the following aggregate amounts of sample marijuana items to an individual recipient licensee in a 30-day period:

(a) 30 grams of usable marijuana;

(b) 5 grams of cannabinoid concentrates or extracts; and

(c) 3 units of sale of any individual cannabinoid product.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1360
Quality Control Samples

(1) Producer and processor licensees may provide sample marijuana items directly to their own license representatives for the purpose of quality control and product development.

(2) The sample marijuana items may not be consumed or used on a licensed premises.

(3) The sample marijuana items may not be provided to or resold to another licensee or consumer.

(4) Any sample provided under this rule must be recorded in CTS.

(5) A producer licensee is limited to providing a total of 28 grams of usable marijuana per harvest lot or 1% of each harvest lot, whichever is smaller.

(6) A processor licensee is limited to providing a total of the following amounts of sample marijuana items:

(a) 5 grams of cannabinoid concentrates or extracts per process lot or 1% of each process lot, whichever is smaller; and

(b) 12 individual units of sale per process lot for other cannabinoid products.

Stat. Auth.: ORS 475B.025, 475B.070 & 475B.090
Stats Implemented: ORS 475B.025, 475B.070 & 475B.090
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1400
Security Plans

(1) An applicant must have a security plan. The Commission will not conduct any pre-licensing inspection under OAR 845-025-1090(3) until it has approved an applicant's security plan.

(2) The Commission must notify an applicant in writing whether the security plan has been approved. If the security plan is approved with a waiver granted under OAR 845-025-1405, the notice must specifically describe the alternate safeguards that are required and, if time limited, must state the time period the security plan is in effect.

(3) A licensee must notify the Commission of any proposed changes to a security plan and must have approval prior to implementing any change. The Commission will notify a licensee whether the change is approved in the same manner described in subsection (2) of this rule.

(4) The Commission may withdraw approval of the security plan at any time if there have been one or more documented instances of theft or loss of marijuana items on the licensed premises within the past year. If the Commission withdraws its approval of the security plan, the licensee will be given a reasonable period of time to modify the plan and if the security plan was approved with a waiver of any security requirements, will be given a reasonable period of time to come into compliance with the security requirements that were waived.

(5) Failure to comply with the terms of an approved security plan is a Category III violation.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1405
Security Waivers

(1) An applicant or licensee may, in writing, request that the Commission waive one or more of the security requirements described in OAR 845-025-1400 to 845-025-1470 by submitting a security waiver request for Commission approval. The waiver request must include:

(a) The specific rules and subsections of a rule that is requested to be waived;

(b) The reason for the waiver;

(c) A description of an alternative safeguard the licensee can put in place in lieu of the requirement that is the subject of the waiver; and

(d) An explanation of how and why the alternative safeguard accomplishes the goals of the security rules, specifically public safety, prevention of diversion, accountability, and prohibiting access to minors.

(2) The Commission may, in its discretion and on a case by case basis, approve the security waiver if it finds that the alternative safeguard that is proposed meets the goals of the security rules.

(3) Approved security waivers expire at the same time as the underlying license.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1410
Security Requirements

(1) A licensee is responsible for the security of all marijuana items on the licensed premises or in transit, including providing adequate safeguards against theft or diversion of marijuana items and records that are required to be kept.

(2) The licensee must ensure that commercial grade, non-residential door locks are installed on every external door, and gate if applicable, of a licensed premises where marijuana items are present.

(3) During all hours when the licensee is not operating a licensee must ensure that:

(a) All points of ingress and egress from a licensed premises are securely locked and any keys or key codes to the enclosed area remain in the possession of the licensee, licensee representative, or authorized personnel;

(b) All marijuana items on a licensed retailer's premises are kept in a safe or vault as those terms are defined in OAR 845-025-1015; and

(c) All usable marijuana, cut and drying mature marijuana plants, cannabinoid concentrates, extracts or products on the licensed premises of a licensee other than a retailer are kept in a locked, enclosed area within the licensed premises that is secured with at a minimum, a steel door with a steel frame or equivalent, and a commercial grade, non-residential door lock.

(4) A licensee must:

(a) Have an electronic back-up system for all electronic records; and

(b) Keep all video recordings and archived required records not stored electronically in a locked storage area. Current records may be kept in a locked cupboard or desk outside the locked storage area during hours when the licensed business is open.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1420
Alarm System

(1) A licensed premises must have a fully operational security alarm system, activated at all times when the licensed premises is closed for business on all:

(a) All points of egress and ingress to and from the licensed premises; and

(b) Perimeter windows, if applicable.

(2) The security alarm system for the licensed premises must:

(a) Be able to detect unauthorized entry onto the licensed premises and unauthorized activity within any limited access area where mature marijuana plants, usable marijuana, cannabinoid concentrates, extracts or products are present;

(b) Be programmed to notify a the licensee, licensee representative or authorized personnel in the event of an unauthorized entry; and

(c) Have a mechanism to ensure that the licensee, licensee's employees and authorized representatives can immediately notify law enforcement or a security company of any unauthorized entry. This subsection may be satisfied in one of the following ways:

(A) Having at least two operational "panic buttons" located inside the licensed premises that are linked with the alarm system that immediately notifies a security company or law enforcement; or

(B) Having operational "panic buttons" physically carried by all licensee representatives present on the licensed premises that are linked with the alarm system that immediately notifies a security company or law enforcement; or

(C) Having a landline telephone present in all limited access areas that is capable of immediately calling a security company or law enforcement.

(3) A licensee that has at least one authorized representative physically present on the licensed premises at all times when it is closed for business is not required to comply with section (1) and sections (2)(a) and (b) of this rule.

(4) Upon request, licensees shall make all information related to security alarm systems, monitoring and alarm activity available to the Commission.

Stat. Auth.: ORS 475B.025, ORS 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1430
Video Surveillance Equipment

(1) A licensed premises must have a fully operational video surveillance recording system.

(2) Video surveillance equipment must, at a minimum:

(a) Consist of:

(A) Digital or network video recorders;

(B) Cameras capable of meeting the requirements of OAR 845-025-1450 and this rule;

(C) Video monitors;

(D) Digital archiving devices;

(E) A minimum of one monitor on premise capable of viewing video; and

(F) A printer capable of producing still photos.

(b) Have the capability of producing a still photograph from any camera image;

(c) Be equipped with a failure notification system that provides, within one hour, notification to the licensee or an authorized representative of any prolonged surveillance interruption or failure; and

(d) Have sufficient battery backup to support a minimum of one hour of recording time in the event of a power outage.

(3) Except for mounted cameras, all video surveillance equipment and recordings must be stored in a locked secure area that is accessible only to the licensee, licensee representatives and authorized personnel, Commission employees and contractors, and other state or local government officials that have jurisdiction over some aspect of the licensed premises or licensee.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1440
Required Camera Coverage and Camera Placement

(1) A licensed premises must have camera coverage, as applicable, for:

(a) All points of ingress and egress to and from the licensed premises;

(b) All limited access areas as that term is defined in OAR 845-025-1015;

(c) All point of sale areas;

(d) All points of entry to or exit from limited access areas; and

(e) The surveillance room or surveillance area as defined in OAR 845-025-1460(1)(a) and (b); and

(f) Any other area that the Commission believes presents a public safety risk based on the overall operation and characteristics of the licensed premises.

(2) A licensee must ensure that cameras are placed so that they capture clear and certain images of any individual and activity occurring:

(a) Within 15 feet both inside and outside of all points of ingress and egress to and from the licensed premises; and

(b) In all locations within limited access and point of sale areas on the licensed premises.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1450
Video Recording Requirements for Licensed Facilities

(1) A licensee must have cameras that continuously record, 24 hours a day:

(a) In all areas where mature marijuana plants, usable marijuana, cannabinoid concentrates, extracts or products may be present on the licensed premises; and

(b) All points of ingress and egress to and from areas where mature marijuana plants, usable marijuana, cannabinoid concentrates, extracts or products are present.

(2) A licensee must:

(a) In limited access and point of sale areas, use cameras that record at a minimum resolution of 1280 x 720 px and record at 10 fps (frames per second);

(b) In exterior perimeter and areas on the licensed premises that are not limited access areas, use cameras that record at a minimum resolution of 1280 x 720 px and record at least 5 fps, except where coverage overlaps any limited access areas such as entrances or exits and in those overlap areas cameras must record at 10 fps;

(c) Use cameras that are capable of recording in all lighting conditions;

(d) Keep all surveillance recordings for a minimum of:

(A) 90 calendar days for licenses issued or renewed after August 31, 2016; and

(B) 30 calendar days for licensed issued prior to August 31, 2016;

(e) Maintain surveillance recordings in a format approved by the Commission that can be easily accessed for viewing and easily reproduced;

(f) Upon request of the Commission, keep surveillance recordings for periods exceeding the retention period specified in section (2)(d) of this rule;

(g) Have the date and time embedded on all surveillance recordings without significantly obscuring the picture;

(h) Archive video recordings in a format that ensures authentication of the recording as a legitimately-captured video and guarantees that no alterations of the recorded image has taken place;

(i) Make video surveillance records and recordings available immediately upon request to the Commission in a format specified by the Commission for the purpose of ensuring compliance with ORS Chapter 475B and these rules;

(j) Immediately notify the Commission of any equipment failure or system outage lasting 30 minutes or more; and

(k) Back up the video surveillance recordings for the surveillance room or surveillance area off-site.

(3) Notwithstanding the requirements in section (1) of this rule a licensee may stop recording in areas where marijuana items are not present due to seasonal closures or prolonged periods of inactivity. The licensee must provide notice to OLCC when recording is stopped and must keep a log of all times that recording is stopped due to marijuana items not being present. The log and notice must identify which cameras were not recording, the date and time recording stops, the date and time recording resumes or is scheduled to resume, and a description of the reason why the recording stopped and started.

(4) In lieu of complying with subsection (2)(k) of this rule, a licensee may keep all required back up video surveillance recordings on site in the surveillance room or surveillance area as described in OAR 845-025-1460(1)(a) and (b), if that surveillance room or surveillance area:

(a) Is fully enclosed on all sides within a limited access area; and

(b) Is secured by an all metal door within a metal frame with a fire rating of 90 minutes or more and commercial grade, non-residential lock that is kept locked at all times.

(5) Failure to comply with subsections (2)(d)(e), (f), (h) or (i) of this rule is a Category I violation and may result in license revocation.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1460
Location and Maintenance of Surveillance Equipment

(1) A licensee must:

(a) Have the surveillance room or surveillance area in a limited access area; and

(b) Have the surveillance recording equipment housed in a designated, locked, and secured room or other enclosure with access limited to:

(A) The licensee, licensee representatives, and authorized personnel;

(B) Employees of the Commission;

(C) State or local law enforcement agencies for a purpose authorized under ORS Chapter 475B, these rules, or for any other state or local law enforcement purpose; and

(D) Service personnel or contractors.

(2) Off-site storage must be secure and the recordings must be kept in a format approved by the Commission that can be easily accessed for viewing and easily reproduced.

(3) A licensee must keep a current list of all authorized employees and service personnel who have access to the surveillance system and room on the licensed premises.

(4) Licensees must keep a surveillance equipment maintenance activity log on the licensed premises to record all service activity including the identity of any individual performing the service, the service date and time and the reason for service to the surveillance system.

(5) Off-site monitoring of the licensed premises by a licensee or an independent third-party is authorized as long as standards exercised at the remote location meet or exceed all standards for on-site monitoring.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1470
Producer Security Requirements

(1) In addition to the security requirements in OAR 845-025-1400 to 845-025-1460, a producer must effectively prevent public access and obscure from public view all areas of marijuana production. A producer may satisfy this requirement by:

(a) Having an approved security plan as described in OAR 845-025-1400 that demonstrates the producer will effectively prevent public access and obscure from public view all areas of marijuana production;

(b) Fully enclosing indoor production on all sides so that no aspect of the production area is visible from the exterior; or

(c) Erecting a solid wall or fence on all exposed sides of an outdoor production area that is at least eight (8) feet high.

(2) If a producer chooses to dispose of marijuana items by any method of composting, as described in OAR 845-025-7750, the producer must prevent public access to the composting area and obscure the area from public view.

Stat. Auth.: ORS 475B.025 & 475B.070
Stats. Implemented: ORS 475B.025 & 475B.070
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1600
State and Local Safety Inspections

(1) All marijuana licensees may be subject to inspection of licensed premises by state or local government officials to determine compliance with state or local health and safety laws.

(2) A licensee must contact any utility provider to ensure that the licensee complies with any local ordinance or utility requirements such as water use, discharge into the sewer system, or electrical use.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-1620
General Sanitary Requirements

A marijuana licensee must:

(1) Prohibit an individual from working on a licensed premises, until the condition is corrected, who has or appears to have:

(a) An open or draining skin lesion unless the individual wears an absorbent dressing and protective gloves; or

(b) Any illness accompanied by diarrhea or vomiting if the individual has a reasonable possibility of contact with marijuana items on the licensed premises.

(2) Require all persons who work in direct contact with marijuana items conform to hygienic practices while on duty, including but not limited to:

(a) Maintaining adequate personal cleanliness; and

(b) Washing hands thoroughly in an adequate hand-washing area before starting work, prior to having contact with a marijuana item and at any other time when the hands may have become soiled or contaminated.

(3) Provide hand-washing facilities adequate and convenient, furnished with running water at a suitable temperature and provided with effective hand-cleaning and sanitizing preparations and sanitary towel service or suitable drying device.

(4) Properly remove all litter and waste from the licensed premises and maintain the operating systems for waste disposal in an adequate manner so that they do not constitute a source of contamination in areas where marijuana items are exposed.

(5) Provide employees with adequate and readily accessible toilet facilities that are maintained in a sanitary condition and good repair.

(6) Hold marijuana items that can support pathogenic microorganism growth or toxic formation in a manner that prevents the growth of these pathogenic microorganism or formation toxins.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.205
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2000
Definitions

As used in OAR 845-025-2000 to 845-025-2080:

(1) "Canopy" means the surface area utilized to produce mature marijuana plants calculated in square feet and measured using the outside boundaries of any area that includes mature marijuana plants including all of the space within the boundaries.

(2) "Indoor production" means producing marijuana in any manner:

(a) Utilizing artificial lighting on mature marijuana plants; or

(b) Other than "outdoor production" as that is defined in this rule.

(3) "Outdoor production" means producing marijuana:

(a) In an expanse of open or cleared ground; or

(b) In a greenhouse, hoop house or similar non-rigid structure that does not utilize any artificial lighting on mature marijuana plants, including but not limited to electrical lighting sources.

Stat. Auth.: ORS 475B.025, 475B.070 & 475B.075
Stats. Implemented: ORS 475B.025, 475B.070 & 475B.075
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2020
Producer Privileges; Prohibitions

(1) A producer may:

(a) Plant, cultivate, grow, harvest and dry marijuana in the manner approved by the Commission and consistent with ORS 475B and these rules;

(b) Engage in indoor or outdoor production of marijuana, or a combination of the two;

(c) Sell or transport:

(A) Usable marijuana to the licensed premises of a marijuana processor, wholesaler, retailer, laboratory, or research certificate holder;

(B) Whole, non-living marijuana plants that have been entirely removed from any growing medium to the licensed premises of a marijuana processor, wholesaler or research certificate holder;

(C) Immature marijuana plants and seeds to the licensed premises of a marijuana producer, wholesaler, retailer or research certificate holder;

(D) Marijuana waste to a producer, processor, wholesaler, or research certificate holder.

(d) Purchase and receive:

(A) Immature marijuana plants and seeds from a producer or wholesaler; and

(B) Marijuana waste from a producer, processor, wholesaler, retailer, laboratory, or research certificate holder.

(C) Usable marijuana produced by the licensee that has been stored by a wholesaler on the producer's behalf.

(e) Allow a laboratory licensee to obtain samples for purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490.

(2) A producer may not sell, deliver, purchase, or receive any marijuana item other than as provided in section (1) of this rule.

(3) No industrial hemp may be present on a producer's licensed premises. Violation of this section is a Category I violation.

Stat. Auth.: ORS 475B.025, 475B.070 & 475B.075
Stats. Implemented: ORS 475B.025, 475B.070 & 475B.075
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2030
Licensed Premises of Producer

(1) The licensed premises of a producer authorized to cultivate marijuana indoors includes all public and private enclosed areas used in the business operated at the location and any areas outside of a building that the Commission has licensed.

(2) The licensed premises of a producer authorized to cultivate marijuana outdoors includes the entire lot or parcel, as defined in ORS 92.010, that the licensee owns, leases or has the right to occupy.

(3) A producer may not engage in any privileges of the license within a residence.

(4) The licensed premises of a producer may not be located at the same physical location or address as a marijuana grow site registered under ORS 475B.420.

Stat. Auth.: ORS 475B.025 & 475B.070
Stats. Implemented: ORS 475B.070 & 475B.080
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2040
Production Size Limitations

(1) Maximum Canopy Size Limits.

(a) Indoor Production.

(A) Micro tier I: Up to 625 square feet

(B) Micro tier II: 626 to 1250 square feet.

(C) Tier I: 1251 to 5000 square feet.

(D) Tier II: 5,001 to 10,000 square feet.

(b) Outdoor production.

(A) Micro tier I: Up to 2,500 square feet.

(B) Micro tier II: 2501 to 5000 square feet.

(C) Tier 1: 5001 to 20,000 square feet.

(D) Tier II: 20,001 to 40,000 square feet.

(c) Mixed production. If a producer intends to have a mixture of indoor and outdoor production the Commission will determine the producer's tiers and canopy sizes by applying the ratio in section (4) of this rule.

(d) For purposes of this section, square footage of canopy space is measured horizontally starting from the outermost point of the furthest mature flowering plant in a designated growing space and continuing around the outside of all mature flowering plants located within the designated growing space.

(e) A producer may designate multiple grow canopy areas at a licensed premises but those spaces must be separated by a physical boundary such as an interior wall or by at least 10 feet of open space.

(f) If a local government adopts an ordinance that would permit a producer to have a higher canopy size limit than is permitted under this rule, the local government may petition the Commission for an increase in canopy size limits for that jurisdiction. If the Commission grants such a petition, the Commission may amend this rule in addition to considering changes to the license fee schedule.

(g) On an annual basis, the Commission will evaluate market demand for marijuana items, the number of person applying for producer licenses or licensed as producers and whether the availability of marijuana items in this state is commensurate with the market demand. Following this evaluation the Commission may amend this rule as needed.

(2) Canopy Size Limit – Designation and Increases.

(a) A producer must clearly identify designated canopy areas and proposed canopy size in the initial license application. A producer may change a designated canopy area within a production type at any time with prior written approval from the Commission, but a producer may only change canopy tiers at the time of renewal in accordance with section (2)(b) or section (3)(a) of this rule.

(b) A producer may submit a request to change canopy tiers at the time the producer submits an application for renewal of the license. The Commission will grant approval of the request to increase the canopy tier for the producer's next licensure term if:

(A) The producer's renewal application is otherwise complete;

(B) There are no bases to deny or reject the producer's renewal application;

(C) The producer has not already reached the applicable maximum canopy size set forth in section (2) of this rule; and

(D) During the preceding year of licensure, the producer has not been found to be in violation, and does not have any pending allegations of violations of ORS 475B or these rules.

(c) The Commission shall give a producer an opportunity to be heard if a request is rejected under this section.

(3) Mixed cultivation methods.

(a) A producer may produce marijuana indoors and outdoors at the same time on the same licensed premises. The Commission must be notified of a producer's plan to engage in the indoor and outdoor production of marijuana at the time of initial licensure or at renewal, and not at any other time. A producer who utilizes mixed production may only change designated canopy areas from one production type to another at the time the producer submits a renewal application.

(b) The Commission must approve the canopy size applicable to each method.

(c) The Commission will use a 4:1 ratio, for outdoor and indoor respectively, to allocate canopy size limits under this section, not to exceed the sum canopy size limits set forth in section (1) of this rule. For example, if a Tier II producer in the first year of licensure has 5,000 square feet of indoor canopy space, then the producer may have up to 20,000 square feet of outdoor canopy space at the same time.

(4) Violations. An intentional violation of this rule is a Category I violation and may result in license revocation. All other violations are Category III violations.

Stat. Auth.: ORS 475B.025, 475B.070 & 475B.075
Stats. Implemented: ORS 475B.075
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2050
Operating Procedures

(1) A producer must:

(a) Establish written standard operating procedures for the production of marijuana. The standard operating procedures must, at a minimum, include when, and the manner in which, all pesticide and or other chemicals are to be applied during the production process; and

(b) Maintain a copy of all standard operating procedures on the licensed premises.

(2) If a producer makes a material change to its standard operating procedures it must document the change and revise its standard operating procedures accordingly. Records detailing the material change must be maintained on the licensed premises by the producer.

Stat. Auth.: ORS 475B.025 & 475B.070
Stats. Implemented: ORS 475B.070
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2060
Start-up Inventory

(1) Marijuana producers may not receive immature marijuana plants or seeds from any source other than from another licensee, except that between January 1, 2016 and December 31, 2017 a marijuana producer may receive immature marijuana plants and seeds from any source within Oregon for up to 90 days following initial licensure by the Commission.

(2) The marijuana producer shall, through CTS, report receipt of the number of immature marijuana plants or seeds received under this section within 24 hours of the plants or seeds arriving at the licensed premises. A producer does not have to document the source of the immature plants or seeds during the 90 day start-up period.

(3) The requirements in section (2) of this rule do not apply during the first ten calendar days of licensure so long as the licensee has ordered UID tags and the UID tags are in transit to the licensee.

(4) Failure to comply with this rule is a Category I violation and could result in license revocation.

Stat. Auth.: ORS 475B.025 & 475B.070
Stats. Implemented: ORS 475B.023 & 475B.070
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2070
Pesticides, Fertilizers and Agricultural Chemicals

(1) Pesticides. A producer may only use pesticides in accordance with ORS chapter 634 and OAR 603, Division 57.

(2) Fertilizers, Soil Amendments, Growing Media. A producer may only use fertilizer, agricultural amendments, agricultural minerals and lime products in accordance with ORS chapter 633.

(3) A producer may not treat or otherwise adulterate usable marijuana with any chemical, biologically active drug, plant, substance, including nicotine, or other compound that has the effect or intent of altering the usable marijuana's color, appearance, weight or smell.

(4) In addition to other records required by these rules, a producer must maintain, at all times and on the licensed premises:

(a) The material safety data sheet (MSDS) for all pesticides, fertilizers or other agricultural chemicals used by the producer in the production of marijuana;

(b) The original label or a copy thereof for all pesticides, fertilizers or other agricultural chemicals used by the producer in the production of marijuana; and

(c) A log of all pesticides, fertilizers or other agricultural chemicals used by the producer in the production of marijuana. The log must include:

(A) The information required to be documented by a pesticide operator in ORS 634.146; and

(B) The unique identification tag number of the cultivation batch or individual mature marijuana plant to which the product was applied, or if applied to all plants on the licensed premises a statement to that affect.

(5) A producer may maintain the records required under this rule in electronic or written form. If electronic, a producer shall maintain a back-up system or sufficient data storage so that records are retained for no less than two years after harvest of any marijuana on which documented products were used. If written, a producer shall ensure that the records are legible and complete, shall keep them in a safe and secure location, and shall retain the records for no less than two years after harvest of any marijuana on which documented products were used.

(6) A producer must make the records required under this rule immediately available during an premises inspection by a Commission regulatory specialist. If the Commission requests copies of the records at any time other than during a premises inspection, a producer shall produce the records upon request.

(7) A violation of sections (1) to (4) of this rule is a Category 1 violation and could result in license revocation.

(8) A failure to keep complete records as required by this rule is a Category III violation. A failure to keep records on the licensed premises, or failure to timely produce records, is a Category III violation.

Stat. Auth.: ORS 475B.025 & 475B.070
Stats. Implemented: ORS 475B.070 & 475B.160
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2080
Harvest Lot Segregation

(1) A producer must, within 45 days of harvesting a harvest lot, physically segregate the harvest lot from other harvest lots, place the harvest lot in a receptacle or multiple receptacles and assign a UID tag to each receptacle that is linked to each plant that was harvested.

(2) Except as allowed under OAR 333-007-0300 to 333-007-0490 for purposes of sampling, or when providing usable marijuana to a processor a producer may not combine harvest lots that are of a different strain, were produced using different growing practices or harvested at a different locations or at different times.

Stat. Auth.: ORS 475B.025 & 475B.070
Stats. Implemented: ORS 475B.070 & 475B.150
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2800
Retailer Privileges; Prohibitions

(1) A retailer is the only licensee that is authorized to sell a marijuana item to a consumer.

(2) A retailer may:

(a) Between the hours of 7:00 AM and 10:00 PM local time, sell marijuana items from the licensed premises to a consumer 21 years of age or older;

(b) Sell and deliver:

(A) Marijuana items to a consumer 21 years of age or older pursuant to a bona fide order as described in OAR 845-025-2880.

(B) Marijuana waste to a producer, processor, wholesaler, or research certificate holder.

(C) Return marijuana items to a producer, processor or wholesaler who transferred the item to the retailer.

(c) Purchase and receive:

(A) Usable marijuana, immature marijuana plants, and seeds from a producer;

(B) Cannabinoid concentrates, extracts, and products from a processor with an endorsement to manufacture the type of product received;

(C) Any marijuana item from a wholesaler;

(D) Any marijuana item from a laboratory; and

(d) Refuse to sell marijuana items to a consumer; and

(e) Allow a laboratory licensee to obtain samples for purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490.

(3) A retailer may not:

(a) Sell more than the following amounts to a consumer at any one time or within one day:

(A) One ounce of usable marijuana;

(B) 16 ounces of a cannabinoid product in solid form;

(C) 72 ounces of a cannabinoid product in liquid form;

(D) Five grams of cannabinoid extracts or concentrates, whether sold alone or contained in an inhalant delivery system;

(E) Four immature marijuana plants; and

(F) Ten marijuana seeds.

(b) Provide free marijuana items to a consumer.

(c) Sell or give away pressurized containers of butane or other materials that could be used in the home production of marijuana extracts.

(d) Discount a marijuana item if the retail sale of the marijuana is made in conjunction with the retail sale of any other items, including other marijuana items.

(e) Sell a marijuana item at a nominal price for promotional purposes.

(f) Permit consumers to be present on the licensed premises or sell to a consumer between the hours of 10:00 p.m. and 7:00 a.m. local time the following day.

(g) Sell any product derived from industrial hemp, as that is defined in ORS 571.300, that is intended for human consumption, ingestion, or inhalation, unless it has been tested, labeled and packaged in accordance with the applicable sections of these rules.

(h) Permit a licensed representative to handle an unpackaged marijuana item without the use of protective gloves, tools or instruments that prevent the marijuana item from coming into contact with the license representative's skin.

(i) Sell, transfer, deliver, purchase, or receive any marijuana item other than as provided in section (2) of this rule.

Stat. Auth.: ORS 475B.025 & 475B.110
Stats. Implemented: ORS 475B.025 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2820
Retailer Operational Requirements

(1) Prior to completing the sale of a marijuana item to a consumer, a retailer must verify that the consumer has a valid, unexpired government-issued photo identification and must verify that the consumer is 21 years of age or older by viewing the consumer's:

(a) Passport;

(b) Driver license, whether issued in this state or by any other state, as long as the license has a picture of the person;

(c) Identification card issued under ORS 807.400;

(d) United States military identification card; or

(e) Any other identification card issued by a state that bears a picture of the person, the name of the person, the person's date of birth and a physical description of the person.

(2) Marijuana items offered for sale by a retailer must be stored in such a manner that the items are only accessible to authorized representatives until such time as the final sale to the consumer is completed.

Stat. Auth.: ORS 475B.025 & 475B.110
Stats. Implemented: ORS 475B.035
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2840
Retailer Premises

(1) The licensed premises of a retailer:

(a) May not be located in an area that is zoned exclusively for residential use.

(b) May not be located within 1,000 feet of:

(A) A public elementary or secondary school for which attendance is compulsory under ORS 339.020; or

(B) A private or parochial elementary or secondary school, teaching children as described in ORS 339.030.

(c) Must be enclosed on all sides by permanent walls and doors.

(2) A retailer must post in a prominent place signs at every:

(a) Entrance that read:

(A) "No Minors Permitted Anywhere on the Premises"; and

(B) "No On-Site Consumption".

(b) Exit from the licensed premises that reads: "Marijuana or Marijuana Infused Products May Not Be Consumed In Public".

(3) A retailer must designate a consumer sales area on the licensed premises where consumers are permitted. The area shall include the portion of the premises where marijuana items are displayed for sale to the consumer and sold and may include other contiguous areas such as a lobby or a restroom. The consumer sales area is the sole area of the licensed premises where consumers are permitted.

(4) All inventory must be stored on the licensed premises.

(5) For purposes of determining the distance between a retailer and a school referenced in subsection (1)(b) of this rule, "within 1,000 feet" means a straight line measurement in a radius extending for 1,000 feet or less in any direction from the closest point anywhere on the boundary line of the real property comprising a school to the closest point of the licensed premises of a retailer. If any portion of the licensed premises is within 1,000 feet of a school as described subsection (1)(b) of this rule an applicant will not be licensed.

Stat. Auth.: ORS 475B.025 & 475B.110
Stats. Implemented: ORS 475B.160 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2860
Consumer Health and Safety Information

A retailer must:

(1) Post at a conspicuous location the following posters prescribed by the Commission, measuring 22 inches high by 17 inches wide that can be downloaded at www.oregon.gov/olcc/marijuana:

(a) A Pregnancy Warning Poster; and

(b) A Poisoning Prevention Poster.

(2) Post at a conspicuous location a color copy of the "Educate Before You Recreate" flyer measuring 22 inches high by 17 inches wide that can be downloaded at WHATSLEGALOREGON.COM.

(3) Distribute to each individual at the time of sale, a Marijuana Information Card, prescribed by the Commission, measuring 3.5 inches high by 5 inches long that can be downloaded at www.oregon.gov/olcc/marijuana.

Stat. Auth.: ORS 475B.025 & 475B.110
Stats. Implemented: ORS 475B.025 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2880
Delivery of Marijuana Items by Retailer

(1) A marijuana retailer may deliver a marijuana item to a residence in Oregon subject to compliance with this rule. For purposes of this rule, "residence" means a dwelling such as a house or apartment but does not include a dormitory, hotel, motel, bed and breakfast or similar commercial business.

(2) Delivery Approval Process.

(a) The retailer must request approval from the Commission prior to undertaking delivery service of marijuana items, on a form prescribed by the Commission that includes a statement that the retailer:

(A) Understands and will follow the requirements for delivery listed in this rule; and

(B) Has taken steps to ensure the personal safety of delivery personnel, including providing any necessary training.

(b) The retailer must receive written approval from the Commission prior to making any deliveries.

(c) The Commission may refuse to review any request for approval that is not complete and accompanied by the documents or disclosures required by the form.

(d) If the Commission denies approval the Commission shall give a retailer the opportunity to be heard.

(e) The Commission may withdraw approval for delivery service at any time if the Commission finds that the retailer is not complying with this rule, the personal safety of delivery personnel is at risk, the retailer's delivery service has been the target of theft, or the delivery service is creating a public safety risk.

(3) Bona Fide Orders.

(a) A bona fide order must be received by an approved retailer from the individual requesting delivery, before 8:00 p.m. on the day the delivery is requested.

(b) The bona fide order must contain:

(A) The individual requestor's name, date of birth, the date delivery is requested and the address of the residence where the individual would like the items delivered;

(B) A document that describes the marijuana items proposed for delivery and the amounts; and

(C) A statement that the marijuana is for personal use and not for the purpose of resale.

(4) Delivery Requirements.

(a) Deliveries must be made before 9:00 p.m. local time and may not be made between the hours of 9:00 p.m. and 8:00 a.m. local time.

(b) The marijuana retailer may only deliver in a motor vehicle to the individual who placed the bona fide order and only to individuals who are 21 years of age or older.

(c) At the time of delivery the individual performing delivery must check the identification of the individual to whom delivery is being made in order to determine that it is the same individual who submitted the bona fide order, that the individual is 21 years of age or older, and must require the individual to sign a document indicating that the items were received.

(d) A marijuana retailer may not deliver a marijuana item to an individual who is visibly intoxicated at the time of delivery.

(e) Deliveries may not be made more than once per day to the same physical address or to the same individual.

(f) Marijuana items delivered to an individual's residence must:

(A) Comply with the packaging rules in OAR 845-025-7000 to 845-025-7060; and

(B) Be placed in a larger delivery receptacle that has a label that reads: "Contains marijuana: Signature of person 21 years of age or older required for delivery".

(g) A retailer may not carry or transport at any one time more than a total of $3000 in retail value worth of marijuana items designated for retail delivery.

(h) All marijuana items must be kept in a lock-box securely affixed inside the delivery motor vehicle.

(i) A manifest must be created for each delivery or series of deliveries and the individual doing the delivery may not make any unnecessary stops between deliveries or deviate substantially from the manifest route.

(5) Documentation Requirements. A marijuana retailer must document the following regarding deliveries:

(a) The bona fide order and the date and time it was received by the retailer;

(b) The date and time the marijuana items were delivered;

(c) A description of the marijuana items that were delivered, including the weight or volume and price paid by the consumer;

(d) Who delivered the marijuana items; and

(e) The name of the individual to whom the delivery was made and the delivery address.

(6) A retailer is only required to maintain the name of an individual to whom a delivery was made for one year.

(7) Prohibitions.

(a) A retailer may deliver marijuana items only to a location within:

(A) The city in which the licensee is licensed, if a licensee is located within a city; or

(B) Unincorporated areas of the county in which the licensee is licensed, if a licensee is located in an unincorporated city or area within the county.

(b) A retailer may not deliver marijuana items to a residence located on publicly-owned land.

(8) Sanction. A violation of any section of this rule that is not otherwise specified in OAR 845-025-8590 is a Category III violation.

Stat. Auth.: ORS 475B.025, 475B.110 & 475B.160
Stats. Implemented: ORS 475B.160
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-2890
Collection of Taxes

(1) A retailer must collect, at the point of sale, the tax imposed on the consumer under ORS 475B.705 and remit the tax to the Oregon Department of Revenue in accordance with Department of Revenue rules.

(2) A violation of this rule is a Category III violation.

(3) An intentional violation of this rule is a Category I violation.

Stat. Auth.: ORS 475B.025 & 475B.160
Stats. Implemented: ORS 475B.025 & 475B.160
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3200
Definitions

For purposes of OAR 845-025-3200 to 845-025-3290:

(1) "Cannabinoid topical" means a cannabinoid product intended to be applied to skin or hair.

(2) "Food" means a raw, cooked, or processed edible substance, or ingredient used or intended for use or for sale in whole or in part for human consumption, or chewing gum.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3210
Endorsements

(1) A marijuana processor may only process and sell cannabinoid products, concentrates or extracts if the processor has received an endorsement from the Commission for that type of processing activity. Endorsements types are:

(a) Cannabinoid edible processor;

(b) Cannabinoid topical processor;

(c) Cannabinoid concentrate processor; and

(d) Cannabinoid extract processor.

(2) An applicant must request an endorsement upon submission of an initial application but may also request an endorsement at any time following licensure.

(3) In order to apply for an endorsement an applicant or processor licensee must submit a form prescribed by the Commission that includes a description of the type of products to be processed, a description of equipment to be used, and any solvents, gases, chemicals or other compounds proposed to be used to create extracts or concentrates.

(4) Only one application and license fee is required regardless of how many endorsements an applicant or licensee requests or at what time the request is made.

(5) An individual processor licensee may hold multiple endorsements.

(6) For the purposes of endorsements any cannabinoid product that is intended to be consumed or ingested orally or applied in the mouth is considered a cannabinoid edible.

(7) If a processor is no longer going to process the product for which the processor is endorsed the processor must notify the Commission in writing and provide the date on which the processing of that product will cease.

(8) The Commission may deny a processor's request for an endorsement if the processor cannot or does not meet the requirements in OAR 845-025-3200 to 845-025-3290 for the endorsement that is requested. If the Commission denies approval the processor has a right to a hearing under the procedures of ORS chapter 183.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090 & 475B.135
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3215
Processor Privileges; Prohibitions

(1) A processor may:

(a) Transfer, sell or transport:

(A) Cannabinoid concentrates, extracts, and products for which the processor has an endorsement to a processor, wholesaler, retailer, or research certificate holder; and

(B) Marijuana waste to a producer, processor, wholesaler, or research certificate holder.

(b) Purchase and receive:

(A) Whole, non-living marijuana plants that have been entirely removed from any growing medium from a producer or wholesaler;

(B) Usable marijuana from a producer or wholesaler;

(C) Cannabinoid concentrates, extracts and products from a processor with an endorsement to manufacture the type of product received;

(D) Marijuana waste from a producer, processor, wholesaler, retailer, laboratory, or research certificate holder; and

(E) Cannabinoid concentrates, extracts, and products produced by the licensee that have been held in bailment by a wholesaler.

(c) Allow a laboratory licensee to obtain samples for purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490.

(2) A processor may not transfer, sell transport, purchase, or receive any marijuana item other than as provided in section (1) of this rule.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.025 & 475B.090
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3220
General Processor Requirements

(1) A processor must:

(a) Use equipment, counters and surfaces for processing that are food-grade and do not react adversely with any solvent being used.

(b) Have counters and surface areas that are constructed in a manner that reduce the potential for development of microbials, molds and fungi and that can be easily cleaned.

(c) Maintain the licensed premises in a manner that is free from conditions which may result in contamination and that is suitable to facilitate safe and sanitary operations for product preparation purposes.

(d) Store all marijuana items not in use in a locked area, including products that require refrigeration in accordance with OAR 845-025-1410.

(e) Assign every process lot a unique identification number and enter this information into CTS.

(3) A processor may not process, transfer or sell a marijuana item:

(a) That by its shape, design or flavor is likely to appeal to minors, including but not limited to:

(A) Products that are modeled after non-cannabis products primarily consumed by and marketed to children; or

(B) Products in the shape of an animal, vehicle, person or character.

(b) That is made by applying cannabinoid concentrates or extracts to commercially available candy or snack food items.

(c) That contains Dimethyl sulfoxide (DMSO).

(4) A processor may not treat or otherwise adulterate a cannabinoid product, concentrate or extract with any non-cannabinoid additive that would increase potency, toxicity or addictive potential, or that would create an unsafe combination with other psychoactive substances. Prohibited additives include but are not limited to nicotine, caffeine, chemicals that increase carcinogenicity or cardiac effects.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3230
Processor Policies and Procedures

A processor must create and maintain written, detailed standard policies and procedures that include but are not limited to:

(1) Instructions for making each cannabinoid concentrate, extract or product.

(2) The ingredients and the amount of each ingredient for each process lot;

(3) The process for making each product;

(4) The number of servings in a process lot;

(5) The intended amount of THC per serving and in a unit of sale of the product;

(6) The process for making each process lot homogenous;

(7) If processing a cannabinoid concentrate or extract:

(a) Conducting necessary safety checks prior to commencing processing;

(b) Purging any solvent or other unwanted components from a cannabinoid concentrate or extract;

(8) Procedures for cleaning all equipment, counters and surfaces thoroughly;

(9) Procedures for preventing growth of pathogenic organisms and toxin formation;

(10) Proper handling and storage of any solvent, gas or other chemical used in processing or on the licensed premises in accordance with material safety data sheets and any other applicable laws;

(11) Proper disposal of any waste produced during processing in accordance with all applicable local, state and federal laws, rules and regulations;

(12) Quality control procedures designed to maximize safety and minimize potential product contamination;

(13) Appropriate use of any necessary safety or sanitary equipment; and

(14) Emergency procedures to be followed in case of a fire, chemical spill or other emergency.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3240
Processor Training Requirements

(1) A processor must have a comprehensive training program that includes, at a minimum, the following topics:

(a) The standard operating policies and procedures;

(b) The hazards presented by all solvents or other chemicals used in processing and on the licensed premises as described in the material safety data sheet for each solvent or chemical; and

(c) Applicable Commission statutes and rules.

(2) At the time of hire and prior to engaging in any processing, and once yearly thereafter, each employee involved in the processing of a cannabinoid concentrate, extract or product must be trained in accordance with the processor's training program.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3250
Cannabinoid Edible Processor Requirements

(1) A cannabinoid edible processor may only process in a food establishment licensed by the Oregon Department of Agriculture (ODA) and must comply with the applicable provisions of OAR 603, Division 21, Division 24, Division 25, with the exception of OAR 603-025-0020(17) and Division 28.

(2) A cannabinoid edible processor may not:

(a) Engage in processing in a location that is operating as a restaurant, seasonal temporary restaurant, intermittent temporary restaurant, limited service restaurant, single-event temporary restaurant, commissary, mobile unit, bed or breakfast, or warehouse licensed under ORS 624;

(b) Share a food establishment with a person not licensed and endorsed by the Commission as a cannabinoid edible processor;

(c) Process food intended for commercial sale that does not contain cannabinoids, at the licensed premises; or

(d) Use a cannabinoid concentrate or extract to process food unless that concentrate or extract was processed by a licensee in a food establishment licensed by the ODA in compliance with the applicable provisions of OAR chapter 603, Division 21, Division 24, Division 25, with the exception of OAR 603-025-0020(17), and Division 28.

(3) A cannabinoid edible processor may share a food establishment with another cannabinoid edible processor if:

(a) The schedule, with specific hours and days that each processor will use the food establishment, is prominently posted at the entrance to the food service establishment and has been approved by the Commission:

(A) The schedule must be submitted to the Commission in writing and will be approved if it demonstrates that use of a shared food establishment by multiple cannabinoid edible processors does not create an increased compliance risk.

(B) A processor licensee may only change the schedule with prior written approval from the Commission.

(b) In addition to the applicable requirements of OAR 845-025-1410, each licensee must designate a separate area to secure any marijuana, cannabinoid products, concentrates or extracts that a licensee stores at the food establishment. The designated area must only be accessible to the licensee. If a cannabinoid edible processor does not store marijuana, cannabinoid products, concentrates or extracts at the food establishment those items must be stored on a licensed premises.

(4) A food establishment used by a cannabinoid edible processor is considered a licensed premises and must meet the security and other licensed premises requirements in these rules.

(5) A cannabinoid edible processor is strictly liable for any violation found at a shared food establishment during that processor's scheduled time or within that processor's designated area in the food establishment.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090 & 475B.135
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3260
Cannabinoid Concentrate and Extract Processor Requirements

(1) Cannabinoid Concentrates or Extracts. A processor with a cannabinoid concentrate or extract endorsement:

(a) May not use Class I solvents as those are classified in the Federal Drug Administration Guidance, Table I, published in the Federal Register on December 24, 1997 (62 FR 67377).

(b) Must:

(A) Only use a hydrocarbon-based solvent that is at least 99 percent purity.

(B) Only use a non-hydrocarbon-based solvent that is food-grade.

(C) Work in an environment with proper ventilation, controlling all sources of ignition where a flammable atmosphere is or may be present.

(D) Use only potable water and ice made from potable water in processing.

(E) If making a concentrate or extract that will be used in a cannabinoid edible, be endorsed as a cannabinoid edible processor and comply with OAR 845-025-3250.

(2) Cannabinoid Extracts. A processor with an endorsement to make cannabinoid extracts:

(a) May not use pressurized canned flammable fuel, including but not limited to butane and other fuels intended for use in camp stoves, handheld torch devices, refillable cigarette lighters and similar consumer products.

(b) Must:

(A) Process in a:

(i) Fully enclosed room clearly designated on the current diagram of the licensed premises.

(ii) Room and with equipment, including all electrical installations that meet the requirements of the Oregon Structural Specialty Code, related Oregon Specialty Codes and the Oregon Fire Code.

(B) Use a professional grade closed loop extraction system designed to recover the solvents and built to codes of recognized and generally accepted good engineering standards, such as those of:

(i) American National Standards Institute (ANSI);

(ii) Underwriters Laboratories (UL); or

(iii) The American Society for Testing and Materials (ASTM).

(C) If using carbon dioxide in processing, use a professional grade closed loop carbon dioxide gas extraction system where every vessel is rated to a minimum of six hundred pounds per square inch.

(D) Have equipment and facilities used in processing approved for use by the local fire code official.

(E) For extraction system engineering services, including but not limited to consultation on and design of extraction systems or components of extraction systems, use the services of a professional engineer registered with the Oregon State Board of Examiners for Engineering and Land Surveying, unless an exemption under ORS 672.060 applies.

(F) Have an emergency eye-wash station in any room in which cannabinoid extract is being processed.

(G) Have all applicable material safety data sheets readily available to personnel working for the processor.

(3) Cannabinoid Concentrates. A processor with an endorsement to make cannabinoid concentrates:

(a) May not:

(A) Use denatured alcohol.

(B) If using carbon dioxide, apply high heat or pressure.

(b) Must only use or store dry ice in a well-ventilated room to prevent against the accumulation of dangerous levels of carbon dioxide.

(c) May use:

(A) A mechanical extraction process;

(B) A chemical extraction process using a nonhydrocarbon-based or other solvent, such as water, vegetable glycerin, vegetable oils, animal fats, isopropyl alcohol or ethanol; or

(C) A chemical extraction process using the hydrocarbon-based solvent carbon dioxide, provided that the process does not involve the use heat over 180 degrees or pressure.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3280
Cannabinoid Topical Processor

A processor with a cannabinoid topical endorsement may not engage in processing in a location that is operating as a restaurant, seasonal temporary restaurant, intermittent temporary restaurant, limited service restaurant or single-event temporary restaurant licensed under ORS 624.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3290
Recordkeeping

(1) A processor must keep records documenting the following:

(a) How much marijuana is in each process lot;

(b) If a product is returned by a licensee, how much product is returned and why;

(c) If a defective product was reprocessed, how the defective product was reprocessed; and

(d) Each training provided in accordance with OAR 845-025-3240, the names of employees who participated in the training, and a summary of the information provided in the training.

(2) A processor must obtain a material safety data sheet for each solvent used or stored on the licensed premises and maintain a current copy of the material safety data sheet and a receipt of purchase for all solvents used or to be used in an extraction process on the licensed premises.

(3) If the Commission requires a processor to submit or produce documents to the Commission that the processor believes falls within the definition of a trade secret as defined in ORS 192.501, the processor must mark each document "confidential" or "trade secret".

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-3500
Wholesale License Privileges; Prohibitions

(1) A wholesale licensee may:

(a) Sell, including sale by auction, transfer and transport:

(A) Any type of marijuana item to a retailer, wholesaler or research certificate holder;

(B) Immature marijuana plants and seeds to a producer;

(C) Usable marijuana to a producer license that the wholesale license has stored on the producer's behalf;

(D) Usable marijuana, cannabinoid extracts and concentrates to a processor licensee; and

(E) Marijuana waste to a producer or processor or research certificate holder.

(b) Purchase or receive:

(A) Any type of marijuana item from a wholesaler.

(B) Cannabinoid concentrates, extracts, and products from a processor with an endorsement to manufacture the type of product received;

(C) Seeds, immature plants or usable marijuana from a producer;

(D)Whole, non-living marijuana plants that have been entirely removed from any growing medium from a producer; and

(E) Marijuana waste from a producer, processor, wholesaler, retailer, laboratory, or research certificate holder.

(c) Transport and store marijuana items on behalf of other licensees, pursuant to the requirements of OAR 845-025-7500 to OAR 845-025-7590.

(d) Allow a laboratory licensee to obtain samples for purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490.

(2) A wholesale licensee may not sell, deliver, purchase, or receive any marijuana item other than as provided in section (1) of this rule.

(3) For purposes of this rule, "marijuana item" does not include a mature marijuana plant.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5000
Laboratory License Privileges; Requirements

(1) A licensed marijuana testing laboratory may:

(a) Obtain samples of marijuana items from licensees or registrants for the purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490 if the laboratory has an accredited scope item for sampling;

(b) Transport and dispose of samples as provided in these rules;

(c) Perform testing on marijuana items in a manner consistent with the laboratory's accreditation by the Authority, these rules, OAR 333-007-0300 to 333-007-0490, and OAR 333, Division 64; and

(d) Transfer the laboratory's marijuana waste to a producer, processor, wholesaler, or research certificate holder.

(2) A licensed marijuana testing laboratory must, upon request of the Oregon Department of Agriculture, provide a test result and any other information or sample material to the Department.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5030
Laboratory Licensing Requirements

(1) General Requirements

(a) A laboratory that intends to collect samples or test marijuana items for producer, processor, wholesale, or retail licensees, or research certificate holders must be licensed by the Commission.

(b) An applicant for a license under this rule must comply with all applicable application requirements in OAR 845-025-1030 and pay the required application and license fees.

(c) A laboratory application is subject to the same application review procedures as other applicants.

(d) In addition to the denial criteria in OAR 845-025-1115, the Commission may refuse to issue a laboratory license for any violation ORS 475B.550 to 475B.590, OAR 333-007-0300 to 333-007-0490, OAR 333, Division 64 or these rules.

(e) In addition to the denial criteria in OAR 845-025-1115, the Commission may refuse to issue a laboratory license to any person who:

(A) Holds a producer, processor, wholesaler or retail license;

(B) Is registered with the authority under ORS 475B.420 and is a person designated to produce marijuana by a registry identification cardholder as that is defined in ORS 475B.410; or

(C) Is registered with the authority under ORS 475B.435 or 475B.450.

(f) Laboratory application and license fees are established in OAR 845-025-1060.

(g) A laboratory that is only accredited to perform sampling may be designated as a Sampling Laboratory for purposes of the licensing fee in OAR 845-025-1060. This designation may only be changed upon license renewal.

(2) Accreditation by the Authority

(a) In addition to the requirements listed in section (1) of this rule, an applicant for a laboratory license must be accredited by the Authority under OAR 333, Division 64 for any cannabis sampling or testing the applicant will perform under OAR 333-007-0300 to 333-007-0490.

(b) An applicant for a license under this rule may apply for licensure prior to receiving accreditation, but the Commission will not issue a license until proof of accreditation is received. (c) The Commission may make efforts to verify or check on an applicant's accreditation status during the licensing process, but an applicant bears the burden of taking all steps needed to secure accreditation and present proof of accreditation to the Commission.

(d) In addition to the denial criteria in OAR 845-025-1115, the Commission may consider an application incomplete if the applicant does not obtain accreditation from the Authority within six months of applying for a license. The Commission shall give an applicant an opportunity to be heard if an application is declared incomplete under this section, but an applicant is not entitled to a contested case proceeding under ORS chapter 183. An applicant whose application is declared incomplete may reapply at any time.

(e) A licensed laboratory must maintain accreditation by the Authority at all times while licensed by the Commission. If a laboratory's accreditation lapses or is revoked at any time for any reason while licensed by the Commission, the laboratory may not perform any activities that are subject to the lapsed or revoked accreditation until it is reinstated.

(f) Exercising license privileges without proper accreditation is a Category I violation and could result in license revocation.

(3) Renewal.

(a) A laboratory must renew its license annually and pay the required renewal fees in accordance with OAR 845-025-1190.

(b) A laboratory renewal application may be denied for any violation of ORS 475B.550 to 475B.590, OAR 333-007-0300 to 333-007-0490, OAR 333, Division 64, or these rules.

Stat. Auth.: ORS 475B.025 & 475B.090
Stats. Implemented: ORS 475B.090
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5045
Laboratory Tracking and Reporting

1) A laboratory licensee is required to utilize CTS for sampling or testing conducted for licensees and research certificate holders and follow all requirements established by OAR 845-025-7500 to OAR 845-025-7590.

(2) A laboratory licensee conducting sampling or testing for licensees is responsible for tracking and entering the following information into CTS:

(a) Receipt of samples for testing, including:

(A) Size of the sample;

(B) Name of licensee or research certificate holder from whom the sample was obtained;

(C) Date the sample was collected; and

(D) UID tag information associated with the harvest or process lot from which the sample was obtained.

(b) Tests performed on samples, including:

(A) Date testing was performed;

(B) What samples were tested for;

(C) Name of laboratory responsible for testing; and

(D) Results of all testing performed.

(c) Disposition of any testing sample material.

(3) A laboratory must also comply with any recordkeeping requirements in OAR 333-007-0300 to 333-007-0490 and OAR 333, Division 64.

Stat. Auth.: ORS 475B.560
Stats. Implemented: ORS 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5060
Laboratory Transportation and Waste Disposal

(1) A laboratory licensee must follow OAR 845-025-7700 and any applicable rules in OAR 333-007-0300 to 333-007-0490 and OAR 333, Division 64 regarding transportation of marijuana items.

(2) A laboratory licensee must follow all rules regarding disposal of samples from marijuana items established in OAR 845-025-7750.

Stat. Auth.: ORS 475B.560
Stats. Implemented: ORS 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5075
Laboratory Licensee Prohibited Conduct

(1) In addition to the prohibitions set forth in OAR 845-025-8520, a laboratory licensee may not: (a) Perform any required marijuana sampling or testing using any sampling or testing methods or equipment not permitted under the laboratory's accreditation through the Authority;

(b) Perform any required marijuana sampling or testing for any licensed marijuana producer, processor, wholesaler or retailer in which the laboratory licensee has a financial interest; or

(c) Engage in any activity that violates any provision of ORS Chapter 475B, OAR 333-007-0300 through OAR 333-007-0490 or OAR 333, Division 64 as applicable or these rules.

(2) The Commission may suspend or revoke a laboratory license for any violation of ORS 475B.550 to ORS 475B.590, OAR 333-007-0300 to 333-007-0490, OAR 333, Division 64, or these rules. The licensee has a right to a hearing under the procedures of ORS chapter 183; OAR chapter 137, division 003; and OAR chapter 845, division 003.

(3) A violation of this rule is a Category I violation and could result in license revocation.

Stat. Auth.: ORS 475B.560
Stats. Implemented: ORS 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5300
Application for Marijuana Research Certificate

(1) The Commission shall issue Marijuana Research Certificates to qualifying public and private researchers who present research proposals that demonstrate:

(a) The proposed research would benefit the state's cannabis industry, medical research or public health and safety; and

(b) The proposed operation and methodology complies with all applicable laws and administrative rules governing marijuana licensees and licensee representatives.

(2) The process for applying for, receiving and renewing a certificate shall be the same as the process for applying for, receiving and renewing a marijuana license under OAR 845-025-1030 to 845-025-1115 except that an applicant for a Marijuana Research Certificate is not subject to the residency requirements in OAR 845-025-1045(2)(b).

(3) In addition to the application requirements in OAR-025-1030 the applicant must also provide:

(a) A clear description of the research proposal;

(b) A description of the researchers' expertise in the scientific substance and methods of the proposed research;

(c) An explanation of the scientific merit of the research plan, including a clear statement of the overall benefit of the applicant's proposed research to Oregon's cannabis industry, medical research, or to public health and safety;

(d) Descriptions of key personnel, including clinicians, scientists, or epidemiologists and support personnel who would be involved in the research, demonstrating they are adequately trained to conduct this research;

(e) A clear statement of the applicant's access to funding and the estimated cost of the proposed research;

(f) A disclosure of any specific conflicts of interest that the researcher or other key personnel have regarding the research proposal;

(g) A description of the research methods demonstrating an unbiased approach to the proposed research; and

(h) If the applicant intends to research the use of pesticides, an experimental use permit issued by Oregon Department of Agriculture pursuant to OAR 603-057-0160.

(4) Research certificates will be granted for up to a three-year term.

(5) The Commission may request that the research certificate holder submit information and fingerprints required for a criminal background check at any time within the research certificate term.

(6) A certificate holder may, in writing, request that the Commission waive one or more of these rules. The request must include the following information:

(a) The specific rule and subsection of a rule that is requested to be waived;

(b) The reason for the waiver;

(c) A description of an alternative safeguard the licensee can put in place in lieu of the requirement that is the subject of the waiver, or why such a safeguard is not necessary; and

(d) An explanation of how and why the alternative safeguard or waiver of the rule protects public health and safety, prevents diversion of marijuana, and provides for accountability.

(7) The Commission may, in its discretion, and on a case-by-case basis, grant the waiver in whole or in part if it finds:

(a) The reason the certificate holder is requesting the waiver is because another state or local law prohibits compliance; or

(b) The certificate holder cannot comply with the particular rule, for reasons beyond the certificate holder's control or compliance with the rule is cost prohibitive; or

(c) Because of the nature of the research, the Commissions finds that compliance with a particular rule is not necessary and that even with the waiver public health and safety can be protected, there is no increased opportunity for diversion of marijuana, and the certificate holder remains accountable.

(8) The Commission must notify the certificate holder in writing whether the request has been approved. If the request is approved the notice must specifically describe any alternate safeguards that are required and, if the waiver is time limited, must state the time period the waiver is in effect.

(9) The Commission may withdraw approval of the waiver at any time upon a finding that the previously approved waiver is not protecting public health and safety or the research certificate holder has other issues with compliance. If the Commission withdraws its approval of the waiver the certificate holder will be given a reasonable period of time to come into compliance with the requirement that was waived.

Stat. Auth.: ORS 475B.560
Stats. Implemented: ORS 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5350
Marijuana Research Certificate Privileges and Prohibitions

(1) A certificate holder may receive marijuana items from a licensee or a registrant under ORS 475B.400 to 475B.525.

(2) A certificate holder may not sell or otherwise transfer marijuana items to any other person except when disposing of waste pursuant to OAR 845-025-7750, or transferring to another certificate holder.

(3) A certificate holder may not conduct any human subject research related to marijuana unless the certificate holder has received approval from an institutional review board that has adopted the Common Rule, 45 CFR Part 46.

(4) All administrative rules adopted by Commission for the purpose of administering and enforcing ORS Chapter; and any rules adopted thereunder with respect to licensees and licensee representatives apply to certificate holders except for those which are inconsistent with this rule.

Stat. Auth.: ORS 475B.560
Stats. Implemented: ORS 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5500
Marijuana Handler Permit and Retailer Requirements

(1) A marijuana worker permit is required for any individual who performs work for or on behalf of a marijuana retailer if the individual participates in:

(a) The possession, securing or selling of marijuana items at the premises for which the license has been issued;

(b) The recording of the possession, securing or selling of marijuana items at the premises for which the license has been issued;

(c) The verification of any document described in ORS 475B.170; or

(d) The direct supervision of a person described in subsections (a) to (c) of this section.

(2) An individual who is required by section (1) of this rule to hold a marijuana worker permit must carry that permit on his or her person at all times when performing work on behalf of a marijuana retailer.

(3) A person who holds a marijuana worker permit must notify the Commission in writing within 24 hours of any arrest or conviction for a misdemeanor or felony.

(4) A marijuana retailer must verify that an individual has a valid marijuana worker permit issued in accordance with OAR 845-025-5500 to 845-025-5590 before allowing the individual to perform any work at the licensed premises.

Stat. Auth.: ORS 475B.215 & 475B.218
Stats. Implemented: ORS 475B.215 & 475B.218
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5520
Marijuana Handler Applications

(1) In order to obtain a marijuana worker permit an individual must submit an application on a form prescribed by the Commission. The application must contain the applicant's:

(a) Name;

(b) Mailing address;

(c) Date of birth;

(d) Signature; and

(e) Response to conviction history questions.

(2) In addition to the application an applicant must submit:

(a) A copy of a driver's license or identification card issued by one of the fifty states in the United States of America or a passport; and

(b) Proof of having passed the worker permit examination.

(3) If an application does not contain all the information requested or if the information required in section (2) of this rule is not provided to the Commission, the application will be returned to the individual as incomplete.

(4) If an application is returned as incomplete, the individual may reapply at any time.

Stat. Auth.: ORS 475B.215 & 475B.218
Stats. Implemented: ORS 475B.215 & 475B.218
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5540
Marijuana Handler Permit Denial Criteria

(1) The Commission must deny an initial or renewal application if the applicant:

(a) Is not 21 years of age or older;

(b) Has had a marijuana license or worker permit revoked for violation of ORS 475B.010 to 475B.395 or any rule adopted under ORS 475B.010 to 475B.395 within two years of the date of the application;

(2) The Commission may deny an initial or renewal application, unless the applicant shows good cause to overcome the denial criteria, if the applicant:

(a) Has been convicted of a felony for possession, manufacture or delivery of a controlled substance within three years of the date the Commission received the application, except for convictions for the manufacture or delivery of marijuana if the date of the conviction is two or more years prior to the date of the application or renewal;

(b) Has been convicted of a felony for a crime involving violence within three years of the date the Commission received the application;

(c) Has been convicted of a felony for a crime of dishonesty or deception, including but not limited to theft, fraud, or forgery, within three years of the date the Commission received the application.

(d) Has more than one conviction for any of the crimes listed in subsections (2)(a) to (d) of this rule within five years of the date the Commission received the application.

(e) Has violated any provision of ORS 475B.010 to 475B.395 or any rule adopted under ORS 475B.010 to 475B.395;

(f) Makes a false statement to the Commission.

(3) If the Commission denies an application under subsection (2)(f) to (g) of this rule the individual will not be eligible for a permit for two years from the date the Commission received the application.

(4) A Notice of Denial must be issued by the Commission in accordance with ORS Chapter 183.

Stat. Auth.: ORS 475B.215 & 475B.218
Stats. Implemented: ORS 475B.215 & 475B.218
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5560
Marijuana Worker Examination Requirements

(1) An individual must, prior to applying for a marijuana worker permit pass the required examination.

(2) An individual must score at least 70 percent on the marijuana worker examination in order to pass.

(3) The Commission may require additional education or training for permit holders at any time, with adequate notice to permit holders.

Stat. Auth.: ORS 475B.215 & 475B.218
Stats. Implemented: ORS 475B.215 & 475B.218
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5580
Marijuana Worker Renewal Requirements

(1) An individual must renew his or her marijuana handler permit every five years by submitting a renewal application, on a form prescribed by the Commission and the applicable fee specified in OAR 845-025-1060.

(2) Renewal applications will be reviewed in accordance with OAR 845-025-5520 and 845-025-5540.

Stat. Auth.: ORS 475B.215 & 475B.218
Stats. Implemented: ORS 475B.215 & 475B.218
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5590
Suspension or Revocation

(1) The Commission may suspend or revoke the permit of any marijuana worker if the worker:

(a) Has been convicted of a felony, except for a felony described ORS 475B.218(4)(a);

(b) Has violated a provision of ORS 475B.010 to 475B.395 or these rules; or

(c) Makes a material false statement to the Commission.

(2) The Commission may suspend or revoke the permit for any marijuana worker for any reasons that would be the basis for denying a permit application under OAR 845-025-5540.

(3) If an individual's permit is revoked under sections (1)(b) or (c) of this rule future applications will be denied if received within two years of the date the final order of revocation was issued.

(4) A notice of suspension or revocation must be issued by the Commission in accordance with ORS 183.

Stat. Auth.: ORS 475B.215 & 475B.218
Stats. Implemented: ORS 475B.215 & 475B.218
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5700
Licensee Testing Requirements

(1) Licensees must comply with the Authority's testing rules in OAR 333-007-0300 to 333-007-0490 and OAR 333, Division 64 prior to the sale or transfer of a marijuana item, as specified in those rules.

(2) A violation is this rule is a Category I violation.

Stat. Auth.: ORS 475B.550 & 475B.555
Stats. Implemented: ORS 475B.550 & 475B.5555
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5720
Labeling, Storage, and Security of Pre-Tested Marijuana Items

(1) Following samples being taken from a harvest or process lot batch a licensee must:

(a) Label the batch with the following information:

(A) The licensee's license number;

(B) The harvest or process lot unique identification number;

(C) The name and accreditation number of the laboratory that took samples and the name and accreditation number of the laboratory that will perform the testing, if different;

(D) The test batch or sample unique identification numbers supplied by the laboratory personnel;

(E) The date the samples were taken; and

(F) In bold, capital letters, no smaller than 12 point font, "PRODUCT NOT TESTED."

(b) Store and secure the batch in a manner that prevents the product from being tampered with or transferred or sold prior to test results being reported.

(c) Be able to easily locate a batch stored and secured under section (1)(b) of this rule and provide that location to the Commission or a laboratory upon request.

(2) A batch may be stored in more than one receptacle as long as the labeling requirements are met.

(3) If the samples pass testing the product may be sold or transferred in accordance with the applicable Commission rules.

(4) If the samples do not pass testing the licensee must comply with OAR 845-025-5740 and 333-007-0450, as applicable.

Stat. Auth.: ORS 475B.550 & 475B.555
Stats. Implemented: ORS 475B.550 & 475B.555
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5730
Wholesaler Coordination of Sampling and Testing

A wholesaler:

(1) May accept a batch, as that term is defined in OAR 333-007-0310 from a producer or processor that:

(a) Has not been sampled or tested in accordance with OAR 333-007-0300 to 333-007-0490, and OAR 333, Division 64 and may order tests and arrange for the sampling and testing of the batch in accordance with OAR 333-007-0300 to 333-007-0490 and OAR 333, Division 64.

(b) Has been sampled but has not yet been tested in accordance with OAR 333-007-0300 to 333-007-0490 and OAR 333, Division 64.

(2) Must secure, label, and store pre-tested marijuana items in accordance with OAR 845-025-5720.

(3) May not transfer or sell a marijuana item unless that marijuana item:

(a) Has been sampled and tested in accordance with OAR 333-007-0300 to 333-007-0490 and OAR 333, Division 64.

(b) Has passed all the required tests in OAR 333-007-0300 to 333-007-0490.

(4) Is jointly and severally responsible for ensuring compliance with OAR 333-007-0300 to 333-007-0490 and OAR 333, Division 64 with the licensee who produced or processed the marijuana item.

Stat. Auth.: ORS 475B.100 & 475B.555
Stats. Implemented: ORS 475B.100 & 475B.555
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5740
Failed Test Samples

If a licensee fails a test the licensee must comply with OAR 333-007-0450.

Stat. Auth.: ORS 475B.550 & 475B.555
Stats. Implemented: ORS 475B.550 & 475B.555
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5760
Audit, Compliance, and Random Testing

(1) The Commission may require a licensee to submit samples identified by the Commission to a laboratory of the licensee's choosing to be tested in order to determine whether a licensee is in compliance with OAR 333-007-0300 through 333-007-0490 and may require additional testing that is not required by these rules.

(2) A laboratory doing audit testing must comply with these rules, to the extent they are applicable, and if conducting testing not required by these rules, may only use Authority approved methods.

(3) The commission must establish a process for the random testing of marijuana items for microbiological contaminants that ensures each licensee tests every product for microbiological contaminants at least once a year.

(4) The Commission may exempt a product that has successfully completed process validation in accordance with OAR 333-007-0440 from testing for microbiological contaminants.

Stat. Auth.: ORS 475B.550 & 475B.555
Stats. Implemented: ORS 475B.550 & 475B.555
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-5790
Marijuana Item Recalls

(1) The Commission may require a licensee to recall any marijuana item that the licensee has sold or transferred upon a finding that circumstances exist that pose a risk to public health and safety. A recall may be based on, but it not limited to, evidence that:

(a) Pesticides were used in the production of marijuana in violation of ORS 634 and OAR 603, Division 57;

(b) A marijuana item is contaminated or otherwise unfit for human use, consumption or application; or

(c) A marijuana item, including any marijuana, usable marijuana, cannabinoid concentrate or extract used in the processing of the marijuana item was not produced or processed by a licensee.

(2) If the Commission finds that a recall is required, the Commission must notify the public and licensees of the recall, may require a licensee to notify an individual to whom a marijuana item was sold and may require that the licensee destroy the recalled product.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025, 475B.030
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7000
Definitions

For the purposes of OAR 845-025-7000 to 845-025-7060:

(1) "Attractive to minors" means packaging, labeling and marketing that features:

(a) Cartoons;

(b) A design, brand or name that resembles a non-cannabis consumer product of the type that is typically marketed to minors;

(c) Symbols or celebrities that are commonly used to market products to minors;

(d) Images of minors

(2) "Cannabinoid" means any of the chemical compounds that are the active constituents of marijuana.

(3) "Cannabinoid concentrate or extract" means a substance obtained by separating cannabinoids from marijuana by a mechanical, chemical or other process.

(4) "Cannabinoid edible" means food or potable liquid into which a cannabinoid concentrate or extract or the dried leaves or flowers of marijuana have been incorporated.

(5)(a) "Cannabinoid product" means a cannabinoid edible or any other product intended for human consumption or use, including a product intended to be applied to a person's skin or hair, that contains cannabinoids or the dried leaves or flowers of marijuana.

(b) "Cannabinoid product" does not include:

(A) Usable marijuana by itself;

(B) A cannabinoid concentrate or extract by itself; or

(C) Industrial hemp, as defined in ORS 571.300.

(6) "Cartoon" means any drawing or other depiction of an object, person, animal, creature or any similar caricature that satisfies any of the following criteria:

(a) The use of comically exaggerated features;

(b) The attribution of human characteristics to animals, plants or other objects, or the similar use of anthropomorphic technique; or

(c) The attribution of unnatural or extra-human abilities, such as imperviousness to pain or injury, X-ray vision, tunneling at very high speeds or transformation.

(7) "Child resistant" means designed or constructed to be significantly difficult for children under five years of age to open and not difficult for adults to use properly.

(8) "Consumer":

(a) Has the meaning given that term in ORS 475B.015; or

(b) Means a patient or designated primary caregiver receiving a transfer from a medical marijuana dispensary.

(9) "Container" means a sealed, hard or soft-bodied receptacle in which a marijuana item is placed prior to being sold to a consumer.

(10) "Exit Package" means a sealed container provided at the retail point of sale in which any marijuana items already within a container are placed.

(11) "Licensee" has the meaning given that term in OAR 845-025-1015.

(12) Marijuana.

(a) "Marijuana" means the plant Cannabis family Cannabaceae, any part of the plant Cannabis family Cannabaceae and the seeds of the plant Cannabis family Cannabaceae.

(b) "Marijuana" does not include industrial hemp, as defined in ORS 571.300.

(13) "Marijuana item" means marijuana, usable marijuana, a cannabinoid product or a cannabinoid concentrate or extract.

(14) "Processing" means the compounding or conversion of marijuana into cannabinoid products or cannabinoid concentrates or extracts.

(15) "Producing" means:

(a) Planting, cultivating, growing, trimming or harvesting marijuana; or

(b) Drying marijuana leaves and flowers.

(16) "Registrant" means a person registered with the Authority under ORS 475B.420, 475B.435, or ORS 475B.450.

(17) Usable Marijuana.

(a) "Usable marijuana" means the dried leaves and flowers of marijuana.

(b) "Usable marijuana" does not include:

(A) The seeds, stalks and roots of marijuana; or

(B) Waste material that is a by-product of producing or processing marijuana.

Stat. Auth.: ORS 475B.615
Stats. Implemented: ORS 475B.600 & 475B.615

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7020
Packaging for Sale to Consumer

(1) The purpose of this rule is to set the minimum standards for the packaging of marijuana items that are sold to the consumer, applicable to:

(a) A licensee; or

(b) On and after October 1, 2016, a registrant who is not exempt from the labeling requirements.

(2) Containers or packaging for marijuana items must protect a marijuana item from contamination and must not impart any toxic or deleterious substance to the marijuana item.

(3) Marijuana items for ultimate sale to a consumer, except for immature plants and seeds, must:

(a) Be packaged in a container that is child-resistant as certified by a qualified third party child-resistant package testing firm or placed within an exit package that is certified by a qualified third party child-resistant package testing firm prior to final sale to consumer;

(b) If the marijuana item is a cannabinoid product, extract or concentrate that contains more than a single serving, be packaged in a container or placed in an exit package that is capable of being resealed and made child resistant again after it has been opened, as certified by a qualified third party child-resistant package testing firm.

(c) Not be packaged or labeled in a manner that is attractive to minors; and

(d) Be labeled in accordance with OAR 333-007-0010 to 333-007-0100.

(4) Packaging may not contain any text that makes an untruthful or misleading statement.

(5) Nothing in this rule:

(a) Prevents the re-use of packaging that is capable of continuing to be child-resistant, as permitted by rules established by the Commission or the Authority; or

(b) Prohibits the Commission or the Authority from imposing additional packaging requirements in their respective rules governing licensees and registrants.

(6) A licensee or registrant must provide to the Commission or the Authority upon that agency's request, additional information about the testing that was performed by the qualified third party child-resistant package testing firm in accordance with 16 CFR 1700.

Stat. Auth.: ORS 475B.615
Stats. Implemented: ORS 475B.070, 475B.090, 475B.100, 475B.110, 475B.615 & 475B.620
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 2-2016(Temp), f. & cert. ef. 2-23-16 thru 8-18-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7030
Labeling for Sale to Consumer

In addition to requirements of OAR 333-007-0010 to 333-007-0100, the Commission may require that marijuana items sold at retail be labeled with a Universal Product Code.

Stat. Auth.: ORS 475B.025 & 475B.605
Stats. Implemented: ORS 475B.025
Hist.; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7040
Wholesaler and Retailer Packaging and Labeling Compliance Requirements

(1) If a wholesaler or a retailer receives a marijuana item that is not packaged or labeled in accordance with OAR 845-025-7000 to 845-025-7060 or 333-007-0010 to 333-007-0100, the wholesaler or retailer must notify the Commission and return the marijuana item to the licensee who transferred the wholesaler or retailer the marijuana item. The wholesaler or retailer must document the return and the reason for the return in the tracking system.

(2) Sale of a marijuana item that is not packaged and labeled in accordance with OAR 845-025-7000 to 845-025-7060 and 333-007-0010 to 333-007-0100 is a category III violation.

Stat. Auth.: ORS 475B.615
Stats. Implemented: ORS 475B.100, 475B.110 & 475B.615
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7060
Packaging and Labeling Pre-approval Process

(1) Prior to a marijuana item being sold to a consumer, a licensee, license applicant or a registrant, if pre-approval is required by the Authority, must submit an application for pre-approval by the Commission.

(a) The initial submission shall be made electronically if required by the Commission. The licensee, license applicant or registrant must submit a physical prototype upon request by the Commission.

(b) If a license applicant submits packages and labels for pre-approval final determination for packages and labels will not be made until the applicant has been issued a license.

(2) Except as provided in sections (7) to (9) of this rule, the packaging and labels must be accompanied by the following:

(a) A fee as specified in OAR 845-025-1060; and

(b) Information including but not limited to

(A) Documentation that the package has been certified for child resistance as defined by 16 CFR 1700 by a qualified third party child-resistant package testing firm.

(B) A picture of and description of the item to be placed in the package.

(3) The Commission will evaluate the packaging and label in order to determine whether:

(a) The packaging:

(A) Has been certified as child resistant by a qualified third party child-resistant package testing firm;

(B) Is attractive to minors or is marketed in a manner attractive to minors;

(C) Contains untruthful or misleading content;

(D) Will contain a marijuana item that is not compliant with ORS 475B, OAR 333, Divisions 7 and 8, or these rules.

(b) The label complies with the Authority's labeling rules, OAR 333-007-0010 to 333-007-0100, or any additional labeling requirements in these rules.

(4) The Commission must review the packaging and labeling and notify the licensee, licensee applicant or registrant whether the packaging and labeling is approved, and if not approved, a description of the packaging or labeling deficiencies.

(5) If a licensee or registrant's label is deficient it must correct the deficiencies and resubmit the label for pre-approval, but the licensee or registrant is not required to submit an additional fee unless the label is found deficient for a second time in which case the licensee must resubmit the packaging or labeling in accordance with section (1) of this rule.

(6) If a licensee, licensee applicant or registrant's original packaging is deficient because it is not child resistant, the licensee, applicant or registrant may:

(a) Correct the deficiencies and resubmit the packaging for pre-approval. The licensee or registrant is not required to submit an additional fee unless the packaging is found deficient for a second time in which case the licensee may resubmit the packaging or labeling in accordance with subsection (1) of this rule; or

(b) The licensee, licensee applicant or registrant may indicate that they wish to satisfy the requirement that a marijuana item be in a container that is child-resistant by using an approved child-resistant exit package.

(7) If a licensee or registrant's packaging is deficient for reasons other than child resistance it must correct the deficiencies and resubmit the packaging for pre-approval, but the licensee, applicant or registrant is not required to submit an additional fee unless the packaging is found deficient for a second time in which case the licensee must resubmit the packaging or labeling in accordance with subsection (1) of this rule.

(8) A licensee, applicant or registrant may submit packaging and labeling for approval on the same application for a product that may have different flavors, colors or sizes if the product and packaging is otherwise identical. Applications for approval of packaging and labeling under this section are subject to a single application fee.

(9) Packages and labels that have been previously approved do not need to be resubmitted if the only changes to the packaging or label are:

(a) Changes in the:

(A) Harvest or processing date;

(B) Strain;

(C) Test results;

(D) Net weight or volume; or

(E) Harvest or process lot numbers.

(b) The deletion of any non-mandatory label information.

(c) The addition, deletion or change in the:

(A) UPC barcodes or 2D mobile barcodes (QR codes); or

(B) Website address, phone number, fax number, or zip code of the licensee or registrant.

(d) The repositioning of any label information on the package, as long as the repositioning of label information is consistent with OAR 333-007-0010 to 333-007-0100.

(10) The Commission may publish a list of previously-approved commercially available packaging. Packaging identified on this list as approved for certain product types does not need to be submitted for approval if used for the type of product for which it is approved and the packaging does not contain any graphics, pictures or logos.

(11) The Commission may publish a list of products whose package and label have been approved, but require an approved exit package in order to meet the child resistance requirement.

(12) Labels for marijuana items do not require pre-approval if they contain only the information required by OAR 333-007-0010 to 333-007-0100 and have no graphics, pictures or logos.

(13) Notwithstanding any provisions of this rule, the Commission may permit or require electronic submission of labels and packaging for approval.

Stat. Auth.: ORS 475B.610 & 475B.620
Stats. Implemented: ORS 475B.610 & 475B.620
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7500
CTS Requirements

(1) A licensee must:

(a) Use CTS as the primary inventory and recording keeping system.

(b) Have a CTS account activated and functional prior to operating or exercising any privileges of the license and must maintain an active account while licensed.

(2) A licensee must have at least one license holder who is a CTS administrator. A licensee may authorize additional license holders or licensee representatives to obtain Administrator accounts.

(3) In order to obtain a CTS administrator account, a license holder must attend and successfully complete all required CTS training, except as provided in section (4) of this rule. The Commission may also require additional ongoing, continuing education for individual administrators to retain his or her CTS administrator account.

(4) A licensee may designate licensee representatives as CTS users. A designated user must be trained by a CTS administrator in the proper and lawful use of CTS. Notwithstanding section (3) of this rule a licensee may designate a licensee representative to attend and successfully complete required CTS training so long as both the licensee and the designated representative obtain CTS administrator accounts.

(5) A licensee must:

(a) Maintain an accurate and complete list of all CTS administrators and CTS users for each licensed premises and must update the list when a new CTS user is trained.

(b) Train and authorize any new CTS users before those users are permitted to access CTS or input, modify, or delete any information in CTS.

(c) Cancel any CTS administrator or user from an associated CTS account if that individual is no longer a licensee representative or the administrator or user has violated OAR 845-025-7500 to 845-025-7590.

(d) Correct any data that is entered into CTS in error.

(6) A licensee is accountable for all actions licensee representatives take while logged into CTS or otherwise conducting inventory tracking activities.

(7) Nothing in this rule prohibits a licensee from using secondary separate software applications to collect information to be used by the business including secondary inventory tracking or point of sale systems. If a licensee uses a separate software application that links to the CTS system it must get approval from the CTS vendor contracting with the Commission and the software application must:

(a) Accurately transfer all relevant CTS data to and from CTS for the purposes of reconciliations with any secondary systems.

(b) Preserve original CTS data when transferred to and from a secondary application.

(8) If at any point a licensee loses access to CTS for any reason, the licensee must keep and maintain comprehensive records detailing all tracking inventory activities that were conducted during the loss of access.

(a) Once access is restored, all inventory tracking activities that occurred during the loss of access must be entered into CTS.

(b) A licensee must document when access to the system was lost and when it was restored.

(c) A licensee may not transport any marijuana items to another licensed premises until such time as access is restored and all information is recorded into CTS.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Stats. Implemented: ORS 475B.150
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7520
Unique Identification (UID) Tags

(1) A licensee must:

(a) Use UID tags issued by a Commission-approved vendor that is authorized to provide UID tags for CTS. Each licensee is responsible for the cost of all UID tags and any associated vendor fees.

(b) Have an adequate supply of UID tags at all times, except that the licensee is not required to have UID tags during the first ten calendar days of licensure so long as UID tags have been ordered and are in transit to the licensee.

(c) Tag individual marijuana plants with a UID tag no later than when each plant reaches a height of eight inches, and properly tag all other inventory with a UID tag pursuant to the system requirements of CTS.

(d) Place tags in a position that can be clearly read by an individual standing next to the item and the tag must be kept free from dirt and debris.

(2) A licensee may only tag and package together identical items for transport to another licensee, except for mixed lots of usable marijuana, cannabinoid concentrates or extracts that are transferred to a processor license to be processed.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Stats. Implemented: ORS 475B.150
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7540
CTS User Requirements

(1) A licensee and any designated CTS administrator or user shall enter data into CTS that fully and transparently accounts for all inventory tracking activities.

(2) A licensee is responsible for the accuracy of all information entered into CTS.

(3) An individual entering data into the CTS system may only use that individual's CTS account. Each CTS administrator and CTS user must have a unique log-on and password, which may not be used by any other person.

(4) A violation of this rule is a Category III violation. Intentional misrepresentation of data entered into the CTS system is a Category I violation.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Stats. Implemented: ORS 475B.150
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7560
System Notifications

A licensee must:

(1) Monitor all compliance notifications from CTS and resolve the issues detailed in the compliance notification in a timely fashion. A licensee may not dismiss a compliance notification in CTS until the licensee resolves the compliance issues detailed in the notification.

(2) Take appropriate action in response to informational notifications received through CTS, including but not limited to notifications related to UID billing, enforcement alerts, and other pertinent information.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Stats. Implemented: ORS 475B.150
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7570
Cultivation Batches

(1) A producer must establish cultivation batches consisting of marijuana plants less than 8 inches tall, seeds and tissue cultures and assign each cultivation batch a unique identification number.

(2) A cultivation batch may not have more than 100 marijuana plants less than 8 inches tall.

(3) A producer may have an unlimited number of cultivation batches at any one time.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.070 & 475B.150
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7580
Reconciliation with Inventory

(1) All licensees must:

(a) Use CTS for all inventory tracking activities at a licensed premises;

(b) Reconcile all on-premises and in-transit marijuana item inventories each day in CTS at the close of business pursuant to system requirements; and

(c) Record all required information for seeds, usable marijuana, cannabinoid concentrates and extracts by weight,

(d) Record the wet weight of all harvested marijuana plants immediately after harvest.

(e) Record all required information for cannabinoid products by unit count but must also record the weight per unit of a product.

(2) The requirements in section (1)(b) of this rule do not apply during the first ten calendar days of licensure so long as the license has ordered UID tags and the UID tags are in transit to the licensee.

(3) In addition to the requirements in section (1) of this rule retailers must record the price and amount of each item sold to consumers and the date of each transaction in CTS at the close of every business day.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.150
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7590
Inventory Audits

The Commission may perform a physical audit of the inventory of any licensee at the agency's discretion and with reasonable notice to the licensee. Variances between the physical audit and the inventory reflected in CTS at the time of the audit, which cannot be attributed to normal moisture variation in usable marijuana, are violations. The Commission may impose a civil penalty, suspend or revoke a licensee for violation of this section.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.160
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7700
Transportation and Delivery of Marijuana Items

(1) Marijuana items may only be transferred between licensed premises by a licensee or licensee representative.

(2) An individual authorized to transport marijuana items must have a valid Oregon Driver's License.

(3) A licensee must:

(a) Keep marijuana items in transit shielded from public view;

(b) Use a vehicle for transport that is:

(A) Insured at or above the legal requirements in Oregon;

(B) Capable of securing (locking) the marijuana items during transportation;

(C) Equipped with an alarm system; and

(D) Capable of being temperature controlled if perishable marijuana items are being transported.

(c) Using CTS, generate a printed transport manifest that accompanies every transport of marijuana items that contains the following information:

(A) The name, contact information of a licensee representative, licensed premises address and license number of the licensee transporting the marijuana items;

(B) The name, contact information of the licensee representative, licensed premises address, and license number of the licensee receiving the delivery;

(C) Product name and quantities (by weight or unit) of each marijuana item contained in each transport, along with the UIDs for every item;

(D) The date of transport and approximate time of departure;

(E) Arrival date and estimated time of arrival;

(F) Delivery vehicle make and model and license plate number; and

(G) Name and signature of the licensee's representative accompanying the transport.

(4) A licensee must generate the manifest required by section (3)(c) of this rule at least 24 hours in advance of initiating transportation if the marijuana items transported pursuant to the manifest exceed:

(a) 25 pounds of usable marijuana;

(b) One pound of cannabinoid concentrate or extract; or

(c) 1000 units of sale of any individual cannabinoid product.

(5) A licensee may not void or change a transportation manifest after departing from the originating premises.

(6) All marijuana items must be packaged in shipping containers and labeled with a UID tag prior to transport.

(7) A licensee must provide a copy of the transport manifest to each licensed premises receiving the inventory described in the transport manifest, but in order to maintain transaction confidentiality, may prepare a separate manifest for each receiving licensed premises.

(8) A licensee must provide a copy of the printed transport manifest and any printed receipts for marijuana items delivered to law enforcement officers or other representatives of a government agency if requested to do so while in transit.

(9) A licensee must contact the Commission immediately, or as soon as possible under the circumstances, if a vehicle transporting marijuana items is involved in any accident that involves product loss.

(10) Upon receipt of inventory a receiving licensee must ensure that the marijuana items received are as described in the transport manifest.

(11) A receiving licensee must separately document any differences between the quantity specified in the transport manifest and the quantities received. Such documentation shall be made in CTS and in any relevant business records.

(12) A licensee must provide temperature control for perishable marijuana items during transport.

(13) Any vehicle transporting marijuana items must travel directly from the shipping licensee to the receiving licensee and must not make any unnecessary stops in between except to other licensed premises receiving inventory.

(14) A licensee must notify the Commission in advance of the location of every stop at an unlicensed location that exceeds two hours in duration.

(15) If the licensee's delivery vehicle is stopped at an unlicensed location the licensee must immediately make the vehicle and its contents available for inspection upon the Commission's request.

(16) A licensee may transport marijuana on behalf of other licensees if the transporting licensee holds a wholesale license.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-7750
Waste Management

(1) A licensee must:

(a) Store, manage and dispose of solid and liquid wastes generated during marijuana production and processing in accordance with applicable state and local laws and regulations which may include but are not limited to:

(A) Solid waste requirements in ORS 459 and OAR 340 Divisions 93 to 96;

(B) Hazardous waste requirements in ORS 466 and OAR 340, Divisions 100 to 106; and

(C) Wastewater requirements in ORS 468B and OAR 340, Divisions 41 to 42, 44 to 45, 53, 55 and 73.

(b) Store marijuana waste in a secured waste receptacle in the possession of and under the control of the licensee.

(c) If the waste is generated post-harvest or if an entire marijuana plant greater than 8 inches tall is designated as waste, the waste must be held on the licensed premises for at least three business days prior to disposal.

(2) A licensee may give or sell marijuana waste to a producer, processor or wholesale licensee or research certificate holder. Any such transaction must be entered into CTS pursuant to OAR 845-025-7500.

(3) In addition to information required to be entered into CTS pursuant to OAR 845-025-7500, a licensee must maintain accurate and comprehensive records regarding waste material that accounts for, reconciles, and evidences all waste activity related to the disposal of marijuana.

Stat. Auth.: ORS 475B.025, 475B.070 & 475B.090
Stats. Implemented: ORS 475B.070, 475B.090, 475B.100 & 475B.150
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8000
Purpose and Application of Rules

(1) The Commission serves the interests of the citizens of Oregon by regulating and prohibiting advertising marijuana items in a manner:

(a) That is attractive to minors;

(b) That promotes excessive use;

(c) That promotes activity that is illegal under Oregon law; or

(d) That otherwise presents a significant risk to public health and safety.

(2) The Commission also serves the interests of Oregonians by allowing advertising for the purpose of informing the public of the availability and characteristics of marijuana.

(3) All marijuana advertising by a licensee must conform to these rules.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8020
Definitions

As used in OAR 845-025-8000 through 845-025-8080:

(1) "Advertising" is publicizing the trade name of a licensee together with words or symbols referring to marijuana or publicizing the brand name of marijuana or a marijuana product.

(2) "Billboard" means a large outdoor advertising structure.

(3) "Handbill" is a flyer, leaflet, or sheet that advertises marijuana.

(4) "Radio" means a system for transmitting sound without visual images, and includes broadcast, cable, on-demand, satellite, or internet programming. Radio includes any audio programming downloaded or streamed via the internet.

(5) "Television" means a system for transmitting visual images and sound that are reproduced on screens, and includes broadcast, cable, on-demand, satellite, or internet programming. Television includes any video programming downloaded or streamed via the internet.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8040
Advertising Restrictions

(1) Marijuana advertising may not:

(a) Contain statements that are deceptive, false, or misleading;

(b) Contain any content that can reasonably be considered to target individuals under the age of 21, including but not limited to images of minors, cartoon characters, toys, or similar images and items typically marketed towards minors;

(c) Specifically encourages the transportation of marijuana items across state lines;

(d) Assert that marijuana items are safe because they are regulated by the Commission or have been tested by a certified laboratory or otherwise make claims that any government agency endorses or supports marijuana;

(e) Make claims that recreational marijuana has curative or therapeutic effects;

(f) Display consumption of marijuana items;

(g) Contain material that encourages the use of marijuana because of its intoxicating effect; or

(h) Contain material that encourages excessive or rapid consumption.

(2) A licensee may not make any deceptive, false, or misleading assertions or statements on any informational material, any sign, or any document provided to a consumer.

(3) A licensee must include the following statement on all advertising:

(a) "Do not operate a vehicle or machinery under the influence of this drug".

(b) "For use only by adults twenty-one years of age and older."

(c) "Keep out of the reach of children."

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8060
Advertising Media, Coupons, and Promotions

(1) The Commission prohibits advertising through handbills that are posted or passed out in public areas such as parking lots and publicly owned property.

(2) A licensee may not utilize television, radio, billboards, print media or internet advertising unless the licensee has reliable evidence that no more than 30 percent of the audience for the program, publication or internet web site in or on which the advertising is to air or appear is reasonably expected to be under the age of 21.

(3) A licensee may not engage in advertising via marketing directed towards location-based devices, including but not limited to cellular phones, unless the marketing is a mobile device application installed on the device by the owner of the device who is 21 years of age or older and includes a permanent and easy opt-out feature.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8080
Removal of Objectionable and Non-Conforming Advertising

(1) A licensee must remove any sign, display, or advertisement if the Commission finds it violates these rules.

(2) The Commission will notify the licensee and specify a reasonable time period for the licensee to remove any sign, display or advertisement that the Commission finds objectionable.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8500
Responsibility of Licensee, Responsibility for Conduct of Others

Each licensee is responsible for violations of any provision of ORS 475B affecting the licensed privileges, or these rules and for any act or omission of a licensee representative that violates any law, administrative rule, or regulation affecting the licensed privileges.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8520
Prohibited Conduct

(1) Sale to a Minor. A licensee or permittee may not sell, deliver, transfer or make available any marijuana item to a person under 21 years of age.

(a) Violation of this section for an intentional sale to a minor by a licensee, permittee or license representative is a Category II violation.

(b) Violation of this section for other than intentional sales is a Category II(b) violation.

(2) Identification. A licensee or license representative must require a person to produce identification as required by ORS 475B.170 before selling or providing a marijuana item to that person. Violation of this section is a Category IV violation.

(3) Access to Premises. A licensee or permittee may not:

(a) During regular business hours for the licensed premises, refuse to admit or fail to promptly admit a Commission regulatory specialist who identifies him or herself and who enters or wants to enter a licensed premises to conduct an inspection to ensure compliance with ORS 475B affecting the licensed privileges; or these rules;

(b) Outside of regular business hours or when the premises appear closed, refuse to admit or fail to promptly admit a Commission regulatory specialist who identifies him or herself and requests entry on the basis that there is a reason to believe a violation of ORS 475B affecting the licensed privileges; or these rules is occurring; or

(c) Once a regulatory specialist is on the licensed premises, ask the regulatory specialist to leave until the specialist has had an opportunity to conduct an inspection to ensure compliance with ORS 475B affecting the licensed privileges; or these rules.

(d) Violation of this section is a Category II violation.

(4) Use or Consumption of Intoxicants on Duty and Under the Influence on Duty.

(a) No licensee, licensee representative, or permittee may consume any intoxicating substances while on duty, except for employees as permitted under OAR 845-025-1230(5)(b). Violation of this subsection is a Category III violation.

(b) No licensee, licensee representative, or permittee may be under the influence of intoxicating substances while on duty. Violation of this subsection is a Category II violation.

(c) Whether a person is paid or scheduled for a work shift is not determinative of whether the person is considered "on duty."

(d) As used in this section:

(A) "On duty" means:

(i) From the beginning to the end of a work shift for the licensed business, including any and all coffee, rest or meal breaks; or

(ii) Performing any acts on behalf of the licensee or the licensed business outside of a work shift if the individual has the authority to put himself or herself on duty.

(B) "Intoxicants" means any substance that is known to have or does have intoxicating effects, and includes alcohol, marijuana, or any other controlled substances.

(5) Permitting Use of Marijuana at Licensed Premises. A licensee or permittee may not permit the use or consumption of marijuana, or any other intoxicating substance, anywhere in or on the licensed premises, or in surrounding areas under the control of the licensee, except for employees as

permitted under OAR 845-025-1230(5)(b). Violation of this section is a Category III violation.

(6) Import and Export. A licensee or permittee may not import marijuana items into this state or export marijuana items out of this state. Violation of this section is a Category I violation and could result in license or permit revocation.

(7) Permitting, Disorderly or Unlawful Conduct. A licensee or permittee may not permit disorderly activity or activity that is unlawful under Oregon state law on the licensed premises or in areas adjacent to or outside the licensed premises under the control of the licensee.

(a) If the prohibited activity under this section results in death or serious physical injury, or involves unlawful use or attempted use of a deadly weapon against another person, or results in a sexual offense which is a Class A felony such as first degree rape, sodomy, or unlawful sexual penetration, the violation is a Category I violation and could result in license or permit revocation.

(b) If the prohibited activity under this section involves use of a dangerous weapon against another person with intent to cause death or serious physical injury, it is a Category II violation.

(c) As used in this section:

(A) "Disorderly activities" means activities that harass, threaten or physically harm oneself or another person.

(B) "Unlawful activity" means activities that violate the laws of this state, including but not limited to any activity that violates a state criminal statute.

(d) The Commission does not require a conviction to establish a violation of this section except as required in ORS 475B.045.

(8) Marijuana as a Prize, Premium or Consideration. No licensee or permittee may give or permit the giving of any marijuana item as a prize, premium, or consideration for any lottery, contest, game of chance or skill, exhibition, or any competition of any kind on the licensed premises.

(9) Visibly Intoxicated Persons. No licensee or permittee may sell, give, or otherwise make available any marijuana item to any person who is visibly intoxicated. Violation of this section is a Category III violation.

(10) Additional Prohibitions. A licensee or permittee may not:

(a) Sell or deliver any marijuana item through a drive-up window.

(b) Sell or offer for sale any marijuana item for a price per item that is less than the licensee's cost for the marijuana item;

(c) Use any device or machine that both verifies the age of the consumer and delivers marijuana to the consumer; or

(d) Deliver marijuana to a consumer off the licensed premises, except that retail licensees may provide delivery as set forth in OAR 845-025-2880.

(e) Violation of this subsection is a Category III violation.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.070, 475B.090, 475B.100, 475B.110, 475B.185, 475B.270 & 475B.275
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8540
Dishonest Conduct

(1) False Statements. A licensee or permittee may not:

(a) Make a false statement or representation to the Commission or law enforcement in order to induce or prevent action or investigation by the Commission or law enforcement. Violation of this subsection is a Category II violation.

(b) If the Commission finds that the false statement or representation was intentional, the Commission may charge the violation as a Category I violation and could result in license or permit revocation.

(2) Marijuana Item Misrepresentations.

(a) A licensee or permittee may not misrepresent any marijuana item to a consumer, licensee, or the public, including:

(A) Misrepresenting the contents of a marijuana item;

(B) Misrepresenting the testing results of a marijuana item;

(C) Misrepresenting the potency of a marijuana item; or

(D) Making representations or claims that the marijuana item has curative or therapeutic effects.

(b) A licensee may not treat or otherwise adulterate usable marijuana with any chemical, biologically active drug, plant, substance, including nicotine, or other compound that has the effect or intent of altering the usable marijuana's color, appearance, weight or smell or that has the effect or intent of increasing potency, toxicity or addictiveness.

(c) A knowing or intentional violation of this section is a Category I violation and could result in license or permit revocation.

(d) Violation of this section in any manner other than knowing or intentional is a Category II violation.

(3) Supply of Adulterated Marijuana Items.

(a) A licensee may not supply adulterated marijuana items.

(b) Violation of this section is a Category I violation and could result in license revocation.

(4) Evidence. A licensee or permittee may not:

(a) Intentionally destroy, damage, alter, remove or conceal potential evidence, or attempt to do so, or ask or encourage another person to do so. Violation of this subsection is a Category I violation and could result in license revocation.

(b) Destroy, damage, alter, remove or conceal potential evidence, or attempt to do so, or ask or encourage another person to do so, in any manner other than intentional. Violation of this subsection is a Category II violation.

(c) Refuse to give, or fail to promptly give, a Commission regulatory specialist or law enforcement officer evidence when lawfully requested to do so. Violation of this subsection is a Category II violation.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100, & 475B.110
Stats. Implemented: ORS 475B.205
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8560
Inspections

(1) The Commission may conduct:

(a) A complaint inspection at any time following the receipt of a complaint that alleges a licensee or permittee is in violation of ORS 475B or these rules;

(b) An inspection at any time if it believes, for any reason, that a licensee or permittee is in violation ORS 475B or these rules; or

(c) Compliance transactions in order to determine whether a licensee or permittee is complying with ORS 475B or these rules.

(2) A licensee, licensee representative, or permittee must cooperate with the Commission during an inspection.

(3) If licensee, licensee representative or permittee fails to permit the Commission to conduct an inspection the Commission may seek an investigative subpoena to inspect the premises and gather books, payrolls, accounts, papers, documents or records.

Stat. Auth.: ORS 475B.025, 475B.070, 475B.090, 475B.100 & 475B.110
Stats. Implemented: ORS 475B.285 & 475B.635
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8570
Uniform Standards for Minor Decoy Operations

(1) Purpose. ORS 475B prevents anyone who has not reached 21 years of age from obtaining marijuana or marijuana items. It is the Commission's intention that decoy operations are to be an impartial test of a licensee's ability and willingness to obey laws on preventing sale marijuana or marijuana items to minors.

(2) Uniform standards for minors used in minor decoy operations:

(a) The minor must be under 21 years of age; and

(b) The minor may not use false identification; and

(c) The minor may not lie about their age.

(3) Uniform standards for coordination with law enforcement agencies. The Commission will coordinate with law enforcement agencies to ensure, to the greatest extent possible, that:

(a) Law enforcement agencies are informed of the Commission's uniform standards for minor decoy operations; and

(b) Law enforcement agencies provide the Commission with copies of their minor decoy policies.

(4) In order for the Commission to process violation cases in a timely manner, law enforcement agencies will be encouraged to provide the Commission with the results of any minor decoy operation.

(5) Licensees or any employee of a licensee must immediately return identification presented by the minor decoy upon request of law enforcement or an OLCC representative.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8580
Suspended Licenses: Posting of Suspension Notice Sign, Activities Allowed During Suspension

(1) Before 7:00 a.m. on the date a license suspension goes into effect, and until the suspension is completed, Commission staff must ensure that a suspension notice sign is posted on each outside entrance or door to the licensed premises.

(2) The suspension notice sign must be posted in a way that allows any person entering the premises to read it. Licensees must use the suspension notice sign provided by the Commission. The sign will state that the license has been suspended by order of the Commission due to violations of the recreational marijuana laws (statutes or administrative rule) of Oregon. If there are multiple licenses at the location, the sign will specify which license privileges have been suspended.

(3) During the period of license suspension, the licensee is responsible for ensuring:

(a) Compliance with all applicable laws and rules; and

(b) That the suspension notice sign is not removed, altered, or covered.

(4) A licensee or licensee representative may not allow the sale, delivery to or from, or receipt of marijuana items at the licensed premises during the period of time that the license is under suspension. During a period of time that the license is under suspension, a recreational marijuana licensee may operate the business provided there is no sale, delivery to or from, or receipt of a marijuana item.

(5) Sanction:

(a) A violation of section (4) of this rule is a Category I violation.

(b) A violation of sections (2) or (3)(b) of this rule is a Category IV violation.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.295 & 475B.635
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8590
Suspension, Cancellation, Civil Penalties, Sanction Schedule

(1) The Commission may suspend or revoke:

(a) A license issued under ORS 475B.010 to 475B.395 or 475B.560.

(b) A marijuana workers permit issued under ORS 475B.215.

(c) A research certificate issued under ORS 475B.235.

(2) The Commission may impose a civil penalty under ORS 475B.295. Civil penalties will be calculated by multiplying:

(a) The number of days in a suspension, if suspension could be or is being imposed, by $165 for licensees or certificate holders; or

(b) The number of days in a suspension, if suspension could be or is being imposed, by $25 for permittees.

(3) The Commission uses the following violation categories:

(a) Category I — Violations that make licensee ineligible for a license;

(b) Category II — Violations that create a present threat to public health or safety;

(c) Category II (b) — Violations for sales to a minor;

(d) Category III — Violations that create a potential threat to public health or safety;

(e) Category IV — Violations that create a climate conducive to abuses associated with the sale or manufacture of marijuana items;

(f) Category V — Violations inconsistent with the orderly regulation of the sale or manufacture of marijuana items.

(4) Violation sanctions

(a) The Commission may sanction a licensee or permittee in accordance with the guidelines set forth in Exhibit 1, incorporated by reference. Exhibit 1 also contains the categories for the most common violations.

(b) Exhibit 1 lists the proposed sanctions for single or multiple violations that occur within a two year period for each category described in section (3) of this rule. The Commission may allege multiple violations in a single notice or may count violations alleged in notices issued within the previous two year period toward the total number of violations. In calculating the total number of violations, the Commission may consider a proposed violation for which the Commission has not yet issued a final order.

(c) The proposed sanctions in Exhibit 1 are guidelines. If the Commission finds one or more mitigating or aggravating circumstances, it may assess a lesser or greater sanction, up to and including revocation. The Commission may decrease or increase a sanction to prevent inequity or to take account of particular circumstances in the case.

(d) Mitigating circumstances include, but are not limited to:

(A) Making a good faith effort to prevent a violation.

(B) Extraordinary cooperation in the violation investigation demonstrating the licensee or permittee accepts responsibility.

(e) Aggravating circumstances include, but are not limited to:

(A) Receiving a prior warning about one or more compliance problems.

(B) Repeated failure to comply with laws.

(C) Failure to use age verification equipment purchased as an offset to a previous penalty.

(D) Efforts by licensee or permittee to conceal a violation.

(E) Intentionally committing a violation.

(F) A violation involving more than one consumer or employee.

(G) A violation involving a juvenile.

(H) A violation resulting in injury or death.

(I) A violation that occurred at a licensed premises that has been granted a security waiver.

(J) Three or more violations within a two-year-period, regardless of the category, where the number of the proposed or final violations indicate a disregard for the law or failure to control the premises.

(5) A licensee may not avoid the sanction for a violation or the application of the provision for successive violations by changing the corporate structure for example, by adding or dropping a partner or converting to another form of legal entity when the individuals who own, operate, or control the business are substantially similar.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.210, 475B.295, 475B.560 & 475B.635
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

845-025-8700
Prohibited Interests in the Marijuana Industry

(1) Definitions. For purposes of this rule:

(a) "Business connections" include, but are not limited to, the following behaviors and relationships:

(A) Knowingly providing anything of value to a business licensed by the Commission in return for something of value except for the exchange of commodities or services that are routinely provided to the general public under the same terms; and

(B) Partnerships with a licensee and similar ventures formed for the purpose of making a profit.

(b) "Employee" means any permanent, temporary or limited duration Commission employee.

(c) "Financial Interest" means knowingly holding an ownership interest as a sole proprietor, partner, limited partner or stockholder, in any marijuana business. This definition excludes any investment that the investor does not control in nature, amount or timing.

(d) "Household member" means all persons living as a family unit in the same dwelling as the commissioner or Commission employee.

(e) "Immediate family" means the spouse, and juvenile dependent children of a commissioner or Commission employee.

(f) "Knowledge" and "knowingly" mean that the person had actual knowledge of or reasonably should have known of the fact in question.

(g) "Marijuana Business" means any business or individual licensed by the Commission under ORS 475B.070, 475B.090, 475B.100, 475B.110 and 475B.560, any business or individual registered by the Authority under ORS 475B.420, 475B.435 and 475B.450 and any business whose primary activity is to provide services to marijuana licensees or registrants.

(h) "Position to take action or make decisions that could affect the marijuana business" means that a commissioner or employee's job duties include the discretion to take actions or make decisions that are reasonably likely to create more than a trivial cost or benefit for a licensed business in money, time or anything else of value

(2) Prohibitions.

(a) Financial Interests. No commissioner, employee, household member or immediate family member may hold a financial interest in a marijuana business.

(b) Employment. No commissioner, employee, household member or family member may be employed by a marijuana business unless the commissioner or employee is not in a position at the Commission to take action or make decisions that could affect the business. An individual is not in a "position to take action or make decisions that could affect the marijuana business" if the Commission removes the employee from actions and decisions affecting the business. The Commission will do so where the removal would not unreasonably effect the employee's ability to perform his or her job duties.

(c) Business Connections. No commissioner, employee, household member or family member may have a business connection described in this rule unless the commissioner or employee is not in a position to take action or make decisions that could affect the licensed business.

(3) Reporting Requirements.

(a) A commissioner or employee who has a business connection association with a marijuana business must:

(A) Inform the Commission of the association as soon as the commissioner or employee has knowledge of the association, and

(B) Refrain from participating in any decision that directly affects the marijuana business.

(b) An applicant for a Commission job must disclose all financial interests, current employment relationships and business connections that the applicant, or any person in the applicant's household or immediate family, has with a marijuana business of which the applicant has knowledge. If the Commission determines that a prohibited financial interest, employment relationship or business connection exists, the applicant must divest the financial interest, employment relationship or business connection before he or she may be hired.

(c) A Commission employee must report all financial interests, current employment relationships and business connections that the employee, or any person in the employee's household or immediate family, has with a marijuana business to his or her supervisor as soon as the employee has knowledge of it. If the financial interest, employment relationship or business connection is prohibited, the Commission will set a reasonable time period for divestiture. If divestiture does not occur within the given time period, the Commission will terminate the employee's employment.

(4) Disciplinary Action. The Commission will appropriately discipline any employee, up to and including termination, who:

(a) Fails to report a prohibited financial interest, employment relationship or business connection as required under this rule, or

(b) Knowingly acquires or establishes a financial interest, employment relationship or business connection prohibited under this rule.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16

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Rule Caption: The amendments and repeal align the rule with the statutory changes made in SB 583.
Adm. Order No.: OLCC 7-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 4-1-2016
Rules Amended: 845-005-0417, 845-006-0392, 845-006-0396
Rules Repealed: 845-005-0420
Subject: Senate Bill 583 passed by the legislature has an effective date of January 1, 2016.

The amendments in the bill added to and revised the qualifications and requirements for the direct shipment of malt beverages, wine, and cider directly to a resident of Oregon. Staff used the temporary rule making process to enact the legislative changes then engaged industry partners through the permanent rulemaking process to hone the rule package.

The amendments and repeal align the rule with the statutory changes made in SB 583
Rules Coordinator: Bryant Haley—(503) 872-5136

845-005-0417
Qualifications for Direct Shipment and Retail Delivery of Malt Beverages, Wine, or Cider to a Resident of Oregon

ORS 471.282 allows a person with a Direct Shipper Permit to sell and deliver malt beverages, wine or cider directly to a resident of Oregon who is at least 21 years of age. 471.186 allows an off-premises sales licensee to deliver malt beverages, wine and cider to a resident of Oregon who is at least 21 years of age.

(1) A Direct Shipper Permit allows the delivery of only the type of alcohol allowed by the license that authorizes the person to hold a Direct Shipper Permit. Only the following persons may qualify for a Direct Shipper Permit:

(a) A person holding a brewery-public house license issued under ORS 471.200, a brewery license issued under ORS 471.220, a winery license issued under ORS 471.223, or a grower sales privilege license issued under 471.227. These licenses are issued with a Direct Shipper Permit.

(b) A person holding a temporary sales license issued under ORS 471.190 that is also a nonprofit trade association and that has a membership primarily composed of persons holding winery licenses issued under 471.223 and grower sales privilege licenses issued under 471.227.

(c) A person holding a license issued by another state within the United States that authorizes the manufacture of malt beverages, wine, or cider. The person in the other state may deliver malt beverages only if that state allows Oregon licensees to deliver malt beverages directly to a resident of that state.

(d) A person holding a license issued by another state within the United States that authorizes the sale of wine or cider produced only from grapes or other fruit grown under the control of the licensee.

(e) A person holding a license issued by another state within the United States that authorizes the sale of malt beverages, wine, or cider at retail for consumption off the licensed premises. The person in the other state may deliver malt beverages only if that state allows Oregon licensees to deliver malt beverages directly to a resident of that state.

(2) Application for a Direct Shipper Permit. A person described under subsections (1)(b)–(e) of this rule must make application to the Commission and receive a Direct Shipper Permit from the Commission before shipping any malt beverages, wine or cider directly to a resident of Oregon. Applicants must apply in writing using the forms provided by the Commission and submit the required fee. The Commission may require additional forms, documents, or information as part of the application. The Commission may refuse to process any application that is not complete or not accompanied by the documents or disclosures required by the form or the Commission.

(3) The Commission may revoke or refuse to issue or renew a Direct Shipper Permit if the permit holder or applicant fails to qualify for the permit under this rule or a refusal basis applies under ORS Chapter 471 or any other rule of the Commission and good cause does not overcome the refusal basis.

(4) A Direct Shipper Permit issued under subsections (1)(c)–(e) of this rule must be renewed annually.

(a) If the person holds the permit based on a license issued by another state, the permit may be renewed by applying in writing using the forms provided by the Commission and submitting the required fee. The Commission may require additional forms, documents, or information as part of the application.

(b) If the person holds the permit based on an annual license issued by this state, the permit may be renewed at the same time that the license is renewed.

(5) Same-Day and Next-Day Delivery.

(a) The privilege of next-day delivery of malt beverages, wine, and cider is included with a Direct Shipper Permit and an off-premises sales license.

(b) A person who holds, or is applying for, a Direct Shipper Permit or an off-premises sales license issued by the Commission who intends to provide the service of same-day delivery of malt beverages, wine, or cider to a resident of Oregon must make application to the Commission upon forms to be furnished by the Commission and receive approval from the Commission prior to beginning the same-day delivery service. The application for same-day delivery approval shall include a statement that the person understands and will follow the same-day delivery requirements listed in OAR 845-006-0392 and 845-006-0396.

(6) The Commission may refuse to process any application required under this rule if the application is not complete and accompanied by the documents or disclosures required by the form. The Commission shall give applicants the opportunity to be heard if the Commission refuses to process an application. A hearing under this subsection is not subject to the requirements for contested case proceedings under ORS Chapter 183.

Stat. Auth.: ORS 471, 471.030, 471.040, 471.186 & 471.730(1) & (5)
Stats. Implemented: ORS 471.155, 471.186, 471.282 & 471.305
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 5-2015(Temp), f. 12-22-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 7-2016, f. 6-28-16, cert. ef. 6-29-16

845-006-0392
Requirements for Direct Shipment and Delivery 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. A container must not hold more than two gallons.

(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.

(h) If the container is a securely-covered container it must be an empty container supplied by the resident. The permit holder or licensee may sell an empty container to the resident prior to or at the time of filling the container.

(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 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 retained 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 an off-premises sales 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;

(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 (i.e. at least 75 percent of the retail cost of the order must be items other than alcohol);

(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;

(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 1500 milliliters of wine or cider (approximately two standard bottles) per day per Oregon residence; or

(e) Receive the order from the resident between 7:01 pm and 9:00 pm on the day the order is delivered, ensure that the wine or cider is delivered before 10:00 pm, and deliver not more than a total of 750 milliliters of wine or cider (approximately one standard 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 471.244.

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; OLCC 13-2013, f. 12-12-13, cert. ef. 1-1-14; OLCC 5-2015(Temp), f. 12-22-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 7-2016, f. 6-28-16, cert. ef. 6-29-16

845-006-0396

Requirements for Direct Shipment and Delivery of Malt Beverages to a Resident of Oregon

(1) A person may sell and ship malt beverages 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 may ship:

(a) Only malt beverages. A container must not hold more than two gallons. Despite this requirement, a factory-sealed container from an off-premises sales licensee 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.

(h) If the container is a securely-covered container it must be an empty container supplied by the resident. The permit holder or licensee may sell an empty container to the resident prior to or at the time of filling the container.

(3) A licensee must retain a record for a minimum of eighteen months of the amount of alcohol contained in the shipment to the resident.

(4) If the licensee ships via a for-hire carrier, in addition to complying with sections (1), (2), and (3) of this rule, the licensee must use a for-hire carrier with a plan approved by the Commission under OAR 845-005-0424.

(5) If the licensee does not use a for-hire carrier, in addition to complying with sections (1), (2), and (3) of this rule, the person delivering the malt beverage must:

(a) Be age 18 or over;

(b) Verify 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 retained 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.

(6) Same-day delivery for a permit holder. If a permit holder has also obtained approval to make same-day delivery of malt beverages, in addition to complying with sections (2) and (3) and either (4) or (5) 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 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.

(7) Same-day delivery for an off-premises sales licensee. If the licensee is approved to make same-day delivery of malt beverages, in addition to complying with sections (1), (2), and (3) and either (4) or (5) 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;

(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 (i.e. at least 75 percent of the retail cost of the order must be items other than alcohol);

(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;

(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 160 ounces of malt beverage (approximately two standard six-packs) per day per Oregon residence; or

(e) Receive the order from the resident between 7:01 pm and 9:00 pm on the day the order is delivered, ensure that the malt beverage is delivered before 10:00 pm, and deliver not more than a total of 80 ounces of malt beverage (approximately one standard six-pack) per day per Oregon residence.

(8) Sanction. A violation of any section of this rule is a Category III violation.

(9) A permit holder must:

(a) Allow the Commission to audit the permit holder's records of malt beverage 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 malt beverage 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 malt beverage 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 malt beverage 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 malt beverage 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 471.244.

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; OLCC 13-2013, f. 12-12-13, cert. ef. 1-1-14; OLCC 5-2015(Temp), f. 12-22-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 7-2016, f. 6-28-16, cert. ef. 6-29-16

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Rule Caption: This package updates and simplifies rule language for Agent promotional activities.
Adm. Order No.: OLCC 8-2016
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-29-16
Notice Publication Date: 4-1-2016
Rules Amended: 845-015-0155, 845-015-0175, 845-015-0177, 845-015-0190
Rules Repealed: 845-015-0130
Subject: This package updates and simplifies rule language for Agent promotional activities. Specifically;

- 845-015-0130 is repealed and consolidated into the other rule amendments.
- The amendments to 845-015-0155 and 845-015-0190 are housekeeping changes that update language by changing "sales agency" to "liquor store" and removing "sample" from tastings language.
- The amendments to 845-015-0175 clarify and update the advertising requirements for Retail Sales Agents.
- The amendments to 845-015-0177 adds clarifying definitions and processes for promotional activities and sweepstakes.

Rules Coordinator: Bryant Haley—(503) 872-5136

845-015-0155
Distilled Spirit Tasting in a Retail Liquor Store

(1) The Commission allows sponsors to conduct distilled spirits tastings in retail liquor stores at the sole discretion of the retail sales agent for the purpose of promoting the sponsor's products. For purposes of this rule, "sponsors" are: Oregon Distillery licensees, out-of-state manufacturers of distilled spirits, importers of distilled spirits, distillery representatives, and the employees or agents of Distillery licensees, out-of-state manufacturers, importers, and distillery representatives. Tastings are subject to the requirements and limits described in this rule.

(2) Tasting Sizes, Number of Samples per Participant. The size of each distilled spirits tasting shall be no more than one-quarter fluid ounce of distilled spirits in a single container. The container may also contain non-alcoholic beverages; however, the total amount of liquid in the container may be no more than two ounces. A sponsor may not provide more than one-half ounce total of distilled spirits per participant per day.

(3) The distilled spirits product(s) provided for tastings must be available for sale at the retail liquor store where and when the tasting occurs.

(4) Identified Tasting Area. Retail sales agents who allow tastings at their retail liquor store must identify a specific tasting area. The area must be of a size and design such that the person(s) conducting the tasting can observe and control persons in the area to ensure no minors or visibly intoxicated persons possess or consume alcohol. Customers must remain in the tasting area until they have finished consuming the sample(s). In exclusive retail liquor stores, the tasting area may be the entire retail liquor store. In non-exclusive retail liquor stores, the retail sales agent must identify a tasting area, and keep on file at the retail liquor store a floor plan sketch identifying the tasting area.

(5) Duration of Tastings Allowed. Tastings are limited to a maximum of three consecutive hours per sponsor per retail liquor store per day. Only one sponsor at a time may conduct sample tastings in a retail liquor store.

(6) Server Requirements. Alcohol servers must have valid Oregon service permits.

(7) Record Keeping. The sponsor must keep a record of each tasting they conduct, including the date and location of each event, the products served, and the names of the servers. The sponsor must retain records of tastings for one year.

(8) Sponsor responsibilities. Sponsors must:

(a) Provide the distilled spirits product to be tasted, and remove any remaining product at the end of the tasting;

(b) Provide or pay for a person to serve the distilled spirits being tasted. The server must be a sponsor or an employee or agent of the sponsor;

(c) Not compensate the retail sales agent, or any employee or agent of the retail sales agent to participate in the tasting.

(9) Retail Sales Agent Responsibilities. Retail sales agents are responsible for liquor law violations occurring in the retail liquor store which are not related to tastings.

(10) Violations Associated with the Tasting. In the case of a liquor law violation associated with tasting (for example, service of a sample to a minor or a visibly intoxicated person), both the server and the sponsor may be held responsible for violations of Oregon liquor laws which occur due to or during the tasting. Violations which occur due to a sponsor or server violating the law will not be charged to the retail sales agent.

Stat. Auth.: ORS 471, 471.030, 471.730(1) & (5)
Stats. Implemented: ORS 471.750
Hist.: LCC 27-1986, f. 11-20-86, ef. 1-1-87; OLCC 2-2003, f. 1-27-03, cert. ef. 2-1-03, Renumbered from 845-015-0095; OLCC 9-2004, f. 6-29-04 cert. ef. 7-1-04; OLCC 5-2011, f. 8-15-11, cert. ef. 9-1-11; OLCC 8-2016, f. 6-28-16, cert. ef. 6-29-16

845-015-0175
Advertising by a Retail Sales Agent

(1) The Commission allows advertising by retail sales agents through media and other forms that are not prohibited by statute or rule.

(2) Advertising may not:

(a) Be false, misleading or discriminatory;

(b) Make claims that any government agency endorses or supports the distilled spirits product;

(c) Include materials so appealing to minors that it encourages them to purchase, possess or drink distilled spirits;

(d) Be included in any material that is for the purpose of youth or minor viewership (i.e. school yearbooks)

(e) Use a person appearing to be under 26 years of age displayed drinking distilled spirits;

(f) Use material that encourages the use of distilled spirits because of its intoxicating effect;

(g) Include the words, "OLCC" or "State of Oregon";

(h) Include material that encourages excessive or rapid consumption;

(i) Be purchased or given by a manufacturer, wholesaler, distributor, or a person representing a distillery, or a Full On-Premises licensee on behalf of a retail sales agent, except as otherwise allowed by statute or rule. (See ORS 471.750(4) and OAR 845-015-0177);

(j) Be placed in media that is being purchased by a Full On-Premises licensee or material advertising a Full On-Premises licensee in a liquor store.

(k) Promote a licensee, sweepstake, premium, on-pack or non-tasting distilled spirit events as those terms are defined in OAR 845-015-0177.

(3) To inform the public of distilled spirit access, retail liquor stores must have exterior "Liquor" sign(s) that are highly visible, attractive, easy to read, compatible with the location and that conform to local ordinances.

(a) Retail liquor stores located within another retail business or building may place an exterior sign at the immediate entrance to the retail liquor store.

(b) Exterior signs may be placed off the property that the retail liquor store occupies with written permission from the owner of the property where the sign will be located. Upon request from the Commission, retail sales agents will need to provide evidence of the property owner's permission.

(c) Signs and sign hardware must be maintained, clean, fully functional, undamaged and freshly painted. Signs and hardware that appear worn or faded must be replaced.

(4) All distilled spirit advertising that a retail sales agent uses must conform to this rule. Prior approval of advertising material is not normally required. However, a retail sales agent who fails to comply with this rule may be required to submit future distilled spirit advertising material to the Commission for prior approval to ensure compliance with OLCC rules. The Commission will specify a reasonable period of time during which prior approval is required.

(5) Retail sales agents must remove any sign, display, or advertisement found by the Commission to violate this rule or OAR 845-015-0177, or both rules. The Commission will specify a reasonable time by which the retail sales agent must remove the objectionable advertising.

(6) Retail sales agents may advertise distilled spirits tasting promotions.

(7) Retail sales agents may advertise lottery sales in their retail liquor store advertisements.

Stat. Auth.: ORS 471, 471.030, 471.730(1) & (5) & 471.750
Stats. Implemented: ORS 471.750(2)
Hist.: OLCC 15-1991, f. 9-30-91, cert. ef. 10-1-91; OLCC 13-1996, f. 9-30-96, cert. ef. 10-7-96; OLCC 2-2003, f. 1-27-03, cert. ef. 2-1-03, Renumbered from 845-015-0091; OLCC 10-2003, f. 7-22-03, cert. ef. 9-1-03; OLCC 17-2004, f. 12-22-04, cert. ef. 1-1-05; OLCC 11-2008, f. 8-18-08, cert. ef. 9-1-08; OLCC 8-2016, f. 6-28-16, cert. ef. 6-29-16

845-015-0177
Advertising in a Retail Liquor Store

(1) Definitions: As used in this rule:

(a) "Sweepstake" means a contest for prizes not prohibited by law and offered by a manufacturer or a person representing a distillery.

(b) "Premium" means an item, offered to promote a product, which a person may order from a manufacturer or person representing a distillery. Examples of a premium include t-shirts, watches, and personalized bottle labeling.

(c) "On-pack" means any item approved by the commission that is attached to or packaged with a distilled spirits product.

(2) The Commission allows product signs and displays that:

(a) Comply with this rule, ORS 471.750(4), OAR 845-015-0175(2) and Alcohol and Tobacco Tax and Trade Bureau (TTB) regulations;

(b) Do not obstruct another distillery's products;

(c) Are not placed in a window;

(d) Advertise or display a manufacturer's, wholesaler's, distributor's, or the distillery's product in conjunction with the approved items described in OAR 845-015-0143; and

(e) Advertise a rebate (as allowed by OAR 845-015-0165), sweepstake or offer a premium or an on-pack for the consumer when the sign or display meets the requirements of (a), (b), (c), and (d).

(3) If a retail sales agent chooses to allow signs and displays in the retail liquor store, each manufacturer, wholesaler, distributor, or distillery must be given a reasonable opportunity to advertise.

(4) If the total value of the sign or display in section (3) is $500 or more, then the item can only be loaned to the retail sales agent, must be clearly marked as the property of the manufacturer, wholesaler, distributor, or distillery representative, marked with the date the loan begins, and can only be loaned for a maximum of 90 days per calendar year. At no time can a loan period exceed more than 90 consecutive days. The distillery representative can only have one such sign or display at any one time in any one liquor store. The manufacturer, wholesaler, distributor, or value of a sign or display is the actual cost to the supplier who initially purchased it. Transportation and installation costs are excluded.

(5) Nothing in this rule requires a retail sales agent to order distilled spirits for use in a display, sweepstake or promotion. Empty case boxes may be used, if necessary.

(6) A retail sales agent may not request, accept, give away or remove on-packs or sweepstake, or premium items from the store at any time or otherwise use the items for personal or business gain. Displays and signs may be removed by the manufacturer, wholesaler, distributor, or a person representing a distillery. Retail sales agents may dispose of old and unused displays and signs, but retail sales agents must not use these items for personal or business gain.

(7) The Commission provides price tags which retail sales agents shall place in front of each brand and size of distilled liquor. If a brand is displayed in more than one area, the retail sales agent must provide tags comparable in quality and style as the price tags OLCC provides and that they be placed in front of each brand and size.

(8) A sweepstake or premium offer must not require the purchase of liquor in order to receive a prize, merchandise or other thing(s) of value, unless the manufacturer, wholesaler, distributor, or distillery representative donates the prize or merchandise to a charitable cause or community nonprofit entity. A sweepstake participant may complete an entry blank at a retail liquor store, but a person representing a manufacturer, wholesaler, distributor, or distillery must draw the entry at the end of the promotion and contact the winner. Any sweepstake or premium must be delivered to the winner at a location other than a retail liquor store. Retail sales agents, liquor store personnel, commission staff or their immediate family living in the same household cannot participate in a sweepstake.

(9) When an on-pack is offered, the on-pack item must not be removed or sold separately from the original bottle unless directed by OLCC. Unless an exception is approved by Commission staff, on-packs of liquor must:

(a) Not exceed two 50 ml per original bottle;

(b) Not be a size that has a current listing; and

(c) Be attached only to original bottles 750 ml in size or larger.

(10) The Commission retains the right to remove signs and displays the Commission finds objectionable or are inappropriate for use in a retail liquor store.

Stat. Auth.: ORS 471, 471.030, 471.730(1) & (5) & 471.750
Stats. Implemented: ORS 471.750(2)
Hist.: OLCC 15-1991, f. 9-30-91, cert. ef. 10-1-91; OLCC 5-1994, f. 10-31-94, cert. ef. 11-1-94; OLCC 2-2003, f. 1-27-03, cert. ef. 2-1-03, Renumbered from 845-015-0092; OLCC 10-2003, f. 7-22-03, cert. ef. 9-1-03; OLCC 11-2008, f. 8-18-08, cert. ef. 9-1-08; OLCC 8-2016, f. 6-28-16, cert. ef. 6-29-16

845-015-0190
Resignation Buy-Out Program for Retail Sales Agents

(1) Purpose. The purpose of the Resignation Buy-Out Program is to provide a monetary benefit to all retail sales agents when they resign. Retail sales agents receive the buy-out, in part, to recognize their contribution in building a successful business.

(2) Definitions.

(a) "Solicit," "solicitation" and "soliciting" have the meaning given them under OAR 845-015-0145. These terms also include any act or contact directed at a specific business, Full On-Premises Sales licensee or other like entity for the purpose of asking, encouraging, suggesting, urging or persuading a specific business, Full On-Premises Sales licensee or other entity to purchase distilled spirits from a particular retail liquor store.

(b) "Full On-Premises Sales licensee" means any person or entity holding a Full On-Premises Sales license.

(c) "Commercial Accounts" means any business or association that purchases more than fifty 750 ml bottles of distilled spirits from the store in the twelve months immediately preceding turnover of the store to the incoming agent.

(d) "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.

(3) Calculating the Buy-Out. The Resignation Buy-Out Program requires the incoming retail sales agent to pay the outgoing agent, or the agent's estate, an amount of money (called the buy-out). Except as provided in section (4), the Commission calculates the buy-out by taking three percent of the stores average annual gross distilled spirits sales for the last five years. If a Retail Sales Agent's most current Annual Evaluation is outstanding, they will be eligible for a four percent buy-out percentage. The Commission includes the buy-out amount as part of the financial requirement in the information sheet that all applicants receive.

(4) Recruiting Qualified Applicants. The outgoing agent may supplement the Commission's recruiting process to assure finding qualified applicants. If the Commission's recruiting process does not generate a qualified applicant the outgoing agent will choose to postpone the resignation or to accept a lower buy-out amount. If the agent chooses to accept a lower buy-out, then the outgoing agent and the Commission will agree on a reasonable buy-out amount reduction. The Commission will then re-advertise the store vacancy with the reduced buy-out amount.

(5) Paying the Buy-Out. An incoming agent must pay a buy-out if the effective date of the incoming agent's appointment occurs when the program is in effect. The incoming agent provides payment to the outgoing agent once the Commission has estimated any debt reimbursements to the Commission or the State of Oregon. As a condition of eligibility for the buy-out, the outgoing agent must allow the incoming agent to spend a minimum of 12 working days at the store working productively together before the store takeover, unless the incoming agent declines the opportunity in writing. During the 12-day period, the outgoing agent will introduce the incoming agent to Full On-Premises Sales licensees and commercial accounts, and orient the incoming agent to all aspects of the store operation except the required training and information provided by Commission staff. The Commission may waive the buy-out requirement at the written request of the outgoing agent.

(6) Family Transfer of Retail Liquor Store When Agent Dies or is Disabled. If an agent dies or becomes unable to operate a retail liquor store due to the agent's disability, ORS 471.752(2) allows the Commission to give preference to a qualified surviving spouse, Domestic Partner, or child, or a qualified spouse, Domestic Partner, or child of the disabled agent, in the appointment of a successor agent. If the Commission does appoint a spouse, Domestic Partner, or child in this situation, the Commission may waive the buy-out requirement at the request of the outgoing agent or the agent's estate after the Commission has estimated any debt reimbursements to the Commission or the State of Oregon.

(7) Probationary Agents. Except as provided in section (9), an agent who resigns during their probationary period is eligible for a buy-out.

(8) Relocating, Adding, or Closing Stores. The Commission reserves the right to relocate any store, and to add or close stores. Neither the State of Oregon nor the Commission is liable for any changes in the volume of distilled spirits sales that may occur following the relocation of one or more stores, or from the addition or closure of one or more stores.

(9) Exceptions. Despite sections (1) and (3), a retail sales agent is not eligible for a buy-out if:

(a) The Commission has terminated the agent for cause relating to fiscal irresponsibility, a history of high shortages exists, or the final estimated audit shortage exceeds the estimated amount of compensation due that agent. In these situations, the incoming agent will be instructed to hold payment until the Commission calculates any dollars owed the Commission or the State of Oregon. At that time the Commission will instruct the incoming agent as to the disbursal of the buy-out fund to the outgoing agent and the Commission. Any amount sent to the Commission in excess of the amount due to the Commission or the State of Oregon will be returned to the outgoing agent upon final financial settlement;

(b) The agent is under suspension;

(c) The agent is a temporary retail sales agent;

(d) The Commission takes over a store for reasons other than suspension or termination. In this situation, the outgoing agent is not eligible for a buy-out until the agent resigns and a permanent incoming agent is appointed and takes over the store; or

(e) The store does not turn over during the time the program is in effect; turnover occurs on the date the Commission conducts the final audit of the permanent outgoing agent.

(10) Non-Compete Provision. If an outgoing agent participates in the buy-out program, the outgoing agent shall not solicit any Full On-Premises Sales licensee or commercial account (customers) of the retail liquor store the outgoing agent is leaving (store) for the purpose of selling or attempting to sell distilled spirits to such customers. The outgoing agent is also prohibited from using a customer list or any other information about the stores customers to assist any agent (other than the incoming agent) in soliciting the stores customers for the purpose of selling distilled spirits. The outgoing agent recognizes that she/he receives consideration for compliance with this section. The prohibitions in this section:

(a) Are limited to a two-year period. The Commission calculates the two-year prohibition beginning on the date the store is turned over to the incoming agent;

(b) Relate only to Full On-Premises Sales licensees and commercial accounts that have made a purchase from the store within the twelve months immediately preceding turnover of the store to the incoming agent;

(c) Apply only within:

(A) A geographic radius of ten miles from the location of the store if the store is located in a metropolitan or suburban area;

(B) A geographic radius of twenty-five miles from the location of the store for all other areas of the state;

(d) Do not prohibit an agent's ability to advertise under OAR 845-015-0175.

(11) Violation of Section (10). If, during the two-year period:

(a) An outgoing agent violates section (10) of this rule, the incoming agent may take legal action against the outgoing agent;

(b) An outgoing agent violates section (10) of this rule, the Commission may take legal action against the outgoing agent;

(c) The Commission terminates the Resignation Buy-Out Program, the non-compete provisions in section (10) remain in effect.

(12) No Contract Rights in Buy-Out. No agent shall have any entitlement to, or expectation of receiving, any buy-out. The institution and continuation or termination of the buy-out program constitutes unilateral regulatory action by the Commission, and gives no agent any contractual right or expectation in any buy-out payment. The Commission reserves the right to repeal or modify this rule, or otherwise terminate the buy-out program at any time.

Stat. Auth.: ORS 471, 471.030, 471.040, 471.730(1) & (5)
Stats. Implemented: ORS 471.750 & 471.752(2)
Hist.: OLCC 14-1996, f. 10-1-96, cert. ef. 1-1-97; OLCC 8-1998(Temp), f. & cert. ef. 9-18-98 thru 3-16-99; OLCC 4-1999, f. 2-16-99, cert. ef. 3-17-99; OLCC 19-2000, f. 12-6-00, cert. ef. 1-1-01; OLCC 2-2003, f. 1-27-03, cert. ef. 2-1-03, Renumbered from 845-015-0032; OLCC 9-2008, f. 6-12-08, cert. ef. 7-1-08; OLCC 15-2011, f. 12-6-11, cert. ef. 1-1-12; OLCC 8-2016, f. 6-28-16, cert. ef. 6-29-16

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Rule Caption: To align the rules with the legislative changes made in 2016.
Adm. Order No.: OLCC 9-2016(Temp)
Filed with Sec. of State: 6-28-2016
Certified to be Effective: 6-30-16 thru 12-26-16
Notice Publication Date:
Rules Adopted: 845-025-2100, 845-025-2900, 845-025-2910, 845-025-3300, 845-025-3310, 845-025-3510, 845-025-3600
Rules Amended: 845-025-1015, 845-025-1030, 845-025-1045, 845-025-1060, 845-025-1090, 845-025-1115, 845-025-2020, 845-025-2030, 845-025-2060, 845-025-2800, 845-025-2840, 845-025-3215, 845-025-3500, 845-025-5000, 845-025-5300, 845-025-5350, 845-025-5540, 845-025-5500

Subject: The Oregon Legislature adopted several bills during the 2016 legislative session that make significant alterations to ORS 475B. This action by the legislature requires the Commission to align the rules with statute.

Specifically, those changes include but are not limited to:

House Bill 4014:

- Repeals the two year residency requirement for marijuana producers, wholesalers, processors, and retailers; Requires OLCC to minimize barriers and, to the extent practicable, expand transportation options in order to assist the viability of marijuana producers that are limited in size and revenue;

- Changes definition of licensed premises for outdoor producers;

- Directs OLCC to adopt rules for businesses that transition from the medical to the recreational system;

- Allows Research Certificates to transfer limited amounts of marijuana items to licensees.

Senate Bill 1511:

- Directs Oregon Liquor Control Commission to register qualified licensees for purposes of producing, processing and selling medically designated marijuana items.

Senate Bill 1598:

- Exempt s persons responsible for a marijuana grow site from acquiring a land use compatibility statement under specified conditions.

- Expands existing worker permit process, including worker education, to producers, wholesalers, and processors.

Following adoption of these temporary rules, the Commission will proceed with permanent rulemaking as required by ORS Chapter 183 while the adopted temporary rules are in place.

Rules Coordinator: Bryant Haley—(503) 872-5136

845-025-1015

Definitions

For the purposes of OAR 845-025-1000 to 845-025-8590, unless otherwise specified, the following definitions apply:

(1) "Adulterated" means to make a marijuana item impure by adding foreign or inferior ingredients or substances. A marijuana item may be considered to be adulterated if:

(a) It bears or contains any poisonous or deleterious substance in a quantity rendering the marijuana item injurious to health, including but not limited to tobacco or nicotine;

(b) It bears or contains any added poisonous or deleterious substance exceeding a safe tolerance if such tolerance has been established;

(c) It consists in whole or in part of any filthy, putrid, or decomposed substance, or otherwise is unfit for human consumption;

(d) It is processed, prepared, packaged, or is held under improper time-temperature conditions or under other conditions increasing the probability of contamination with excessive microorganisms or physical contaminants;

(e) It is processed, prepared, packaged, or held under insanitary conditions increasing the probability of contamination or cross-contamination;

(f) It is held or packaged in containers composed, in whole or in part, of any poisonous or deleterious substance rendering the contents potentially injurious to health;

(g) Any substance has been substituted wholly or in part therefor;

(h) Damage or inferiority has been concealed in any manner; or

(i) Any substance has been added thereto or mixed or packaged therewith so as to increase its bulk or weight, or reduce its quality or strength, or make it appear better or of greater value than it is.

(2) "Authority" means the Oregon Health Authority.

(3) "Business day" means Monday through Friday excluding legal holidays.

(4) "Cannabinoid" means any of the chemical compounds that are the active constituents of marijuana.

(5) "Cannabinoid concentrate" means a substance obtained by separating cannabinoids from marijuana by:

(a) A mechanical extraction process;

(b) A chemical extraction process using a nonhydrocarbon-based or other solvent, such as water, vegetable glycerin, vegetable oils, animal fats, isopropyl alcohol or ethanol; or

(c) A chemical extraction process using the hydrocarbon-based solvent carbon dioxide, provided that the process does not involve the use of high heat or pressure; or

(6) "Cannabinoid edible" means food or potable liquid into which a cannabinoid concentrate, cannabinoid extract or dried marijuana leaves or flowers have been incorporated.

(7) "Cannabinoid extract" means a substance obtained by separating cannabinoids from marijuana by:

(a) A chemical extraction process using a hydrocarbon-based solvent, such as butane, hexane or propane;

(b) A chemical extraction process using the hydrocarbon-based solvent carbon dioxide, if the process uses high heat or pressure; or

(c) Any other process identified by the Commission, in consultation with the authority, by rule.

(8) Cannabinoid Product

(a) "Cannabinoid product" means a cannabinoid edible and any other product intended for human consumption or use, including a product intended to be applied to the skin or hair, that contains cannabinoids or dried marijuana leaves or flowers.

(b) "Cannabinoid product" does not include:

(A) Usable marijuana by itself;

(B) A cannabinoid concentrate by itself;

(C) A cannabinoid extract by itself; or

(D) Industrial hemp, as defined in ORS 571.300.

(9) "Cannabis Tracking System" or "CTS" means the system for tracking the transfer of marijuana items and other information as authorized by ORS 475B.150.

(10) "Common Ownership" means any commonality between individuals or legal entities named as applicants or persons with a financial interest in a license or business proposed to be licensed.

(11) "Compliance transaction" means a single covert, on-site visit in which a Commission authorized representative poses as an authorized representative of a licensee or a consumer and attempts to purchase or purchases a marijuana item from a licensee, or attempts to sell or sells a marijuana item to a licensee.

(12) "Container" means a sealed, hard or soft-bodied receptacle in which a marijuana item is placed prior to being sold to a consumer.

(13) "Contractor" means a person, other than a license representative, who temporarily visits the licensed premises to perform a service, maintenance or repair.

(14) "Commission" means the Oregon Liquor Control Commission.

(15) "Commissioner" means a member of the Oregon Liquor Control Commission.

(16) "Consumer" means a person who purchases, acquires, owns, holds or uses marijuana items other than for the purpose of resale.

(17) "Date of Harvest" means the date the mature marijuana plants in a harvest lot were cut, picked or removed from the soil or other growing media. If the harvest occurred on more than one day, the "date of harvest" is the day the last mature marijuana plant in the harvest lot was cut, picked or removed from the soil or other growing media.

(18) "Designated primary caregiver" has the meaning given that term in ORS 475B.410.

(19)(a) "Financial consideration" means value that is given or received either directly or indirectly through sales, barter, trade, fees, charges, dues, contributions or donations.

(b) "Financial consideration" does not include marijuana, cannabinoid products or cannabinoid concentrates that are delivered within the scope of and in compliance with ORS 475B.245.

(20) "Financial interest" means having an interest in the business such that the performance of the business causes, or is capable of causing, an individual, or a legal entity with which the individual is affiliated, to benefit or suffer financially, and such interests include but are not limited to:

(a) Receiving, as an employee or agent, out-of-the-ordinary compensation, either in the form of overcompensation or under compensation;

(b) Lending money, real property or personal property to an applicant or licensee for use in the business at a commercially unreasonable rate;

(c) Giving money, real property or personal property to an applicant or licensee for use in the business; or

(d) Being the spouse or domestic partner of an applicant or licensee. For purposes of this subsection, "domestic partners" includes adults who qualify for a "domestic partnership" as defined under ORS 106.310.

(21) "Harvest lot" means a specifically identified quantity of marijuana that is uniform in strain, cultivated utilizing the same growing practices and harvested at the same time at the same location and cured under uniform conditions.

(22) "Immature marijuana plant" means a marijuana plant that is not flowering.

(23) "Intended for human consumption" means intended for a human to eat, drink, or otherwise put in the mouth but does not mean intended for human inhalation.

(24) "Invited guests" means family member and close associates of the licensee, not members of the general public.

(25) "Laboratory" means a laboratory certified by the Authority under ORS 438.605 to 438.620 and authorized to sample or test marijuana items for purposes specified in these rules.

(26) "Licensee" means any person who holds a license issued under ORS 475B.070, 475B.090, 475B.100, 475B.110, or 475B.560.

(27) "License holder" includes:

(a) Each applicant listed on an application that the Commission has approved;

(b) Each individual who meets the qualification described in OAR 845-025-1045 and who the Commission has added to the license under OAR 845-025-1030; or

(c) Each individual who has a financial interest in the licensed business and who the Commission has added to the license under OAR 845-025-1030.

(28) "Licensee representative" means an owner, director, officer, manager, employee, agent, or other representative of a licensee, to the extent that the person acts in a representative capacity.

(29) "Limited access area" means a building, room, or other contiguous area on a licensed premises where a marijuana item is produced, processed, stored, weighed, packaged, labeled, or sold, but does not include a point of sale area on a licensed retailer premises.

(30) "Marijuana"

(a) "Marijuana" means the plant Cannabis family Cannabaceae, any part of the plant Cannabis family Cannabaceae and the seeds of the plant Cannabis family Cannabaceae.

(b) "Marijuana" does not include industrial hemp, as defined in ORS 571.300.

(31) "Marijuana flowers" means the flowers of the plant genus Cannabis within the plant family Cannabaceae.

(32) "Marijuana items" means marijuana, cannabinoid products, cannabinoid concentrates and cannabinoid extracts.

(33) "Marijuana leaves" means the leaves of the plant genus Cannabis within the plant family Cannabaceae.

(34) "Marijuana processor" means a person who processes marijuana items in this state.

(35) "Marijuana producer" means a person who produces marijuana in this state.

(36) "Marijuana retailer" means a person who sells marijuana items to a consumer in this state.

(37) "Marijuana wholesaler" means a person who purchases marijuana items in this state for resale to a person other than a consumer.

(38) "Mature marijuana plant" means a marijuana plant that is not an immature marijuana plant.

(39) "Medical grade cannabinoid product, cannabinoid concentrate or cannabinoid extract" means a cannabinoid product, cannabinoid concentrate or cannabinoid extract that has a concentration of tetrahydrocannabinol that is permitted under ORS 475B.625 in a single serving of the cannabinoid product, cannabinoid concentrate or cannabinoid extract for consumers who hold a valid registry identification card issued under ORS 475B.415.

(40) "Micro-Wholesaler" means a marijuana wholesaler licensed by the Commission that only purchases or receives seeds, immature plants or usable marijuana from a producer with a micro tier I or tier II canopy.

(41) "Minor" means any person under 21 years of age.

(42) "Non-Toxic" means not causing illness, disability or death to persons who are exposed.

(43) "Non-profit Dispensary" means a medical marijuana dispensary registered under ORS 475B.450 owned by a nonprofit corporation organized under ORS chapter 65.

(44) "ORELAP" means the Oregon Environmental Laboratory Accreditation Program administered by the Authority pursuant to ORS 438.605 to 438.620.

(45) "Permittee" means any person who holds a Marijuana Workers Permit.

(46) "Person" has the meaning given that term in ORS 174.100.

(47) "Person responsible for a marijuana grow site" or "PRMG" has the meaning given that term in OAR 333-008-0010.

(48) "Premises" or "licensed premises" includes the following areas of a location licensed under section ORS 475B.070, ORS 475B.090, ORS 475B.100, ORS 475B.110 or ORS 475B.560:

(a) All public and private enclosed areas at the location that are used in the business operated at the location, including offices, kitchens, rest rooms and storerooms;

(b) All areas outside a building that the Commission has specifically licensed for the production, processing, wholesale sale or retail sale of marijuana items; and

(c) "Premises" or "licensed premises" does not include a primary residence.

(49) "Primary Residence" means real property inhabited for the majority of a calendar year by an owner, renter or tenant, including manufactured homes and vehicles used as domiciles.

(50) "Processes"

(a) "Processes" means the processing, compounding or conversion of marijuana into cannabinoid products, cannabinoid concentrates or cannabinoid extracts;

(b) "Processes" does not include packaging or labeling.

(51) "Process lot" means:

(a) Any amount of cannabinoid concentrate or extract of the same type and processed at the same time using the same extraction methods, standard operating procedures and batches from the same harvest lot; or

(b) Any amount of cannabinoid products of the same type and processed at the same time using the same ingredients, standard operating procedures and batches from the same harvest lot or process lots of cannabinoid concentrate or extract.

(52) "Producer" means a marijuana producer licensed by the Commission.

(53) "Produces"

(a) "Produces" means the manufacture, planting, cultivation, growing or harvesting of marijuana.

(b) "Produces" does not include:

(A) The drying of marijuana by a marijuana processor, if the marijuana processor is not otherwise producing marijuana; or

(B) The cultivation and growing of an immature marijuana plant by a marijuana processor, marijuana wholesaler or marijuana retailer if the marijuana processor, marijuana wholesaler or marijuana retailer purchased or otherwise received the plant from a licensed marijuana producer.

(54) "Propagate" means to grow immature marijuana plants or to breed or produce the seeds of the plant Cannabis family Cannabaceae.

(55) "Public place" means a place to which the general public has access and includes, but is not limited to, hallways, lobbies and other parts of apartment houses and hotels not constituting rooms or apartments designed for actual residence, and highways, streets, schools, places of amusement, parks, playgrounds and areas used in connection with public passenger transportation.

(56) "Regulatory specialist" means a full-time employee of the Commission who is authorized to act as an agent of the Commission in conducting inspections or investigations, making arrests and seizures, aiding in prosecutions for offenses, issuing citations for violations and otherwise enforcing chapter 471, ORS 474.005 to 474.095, 474.115, 475B.010 to 475B.395, 475B.550 to 475B.590 and 475B.600 to 475B.655, Commission rules and any other statutes the Commission considers related to regulating liquor or marijuana.

(57) "Registry identification cardholder" or "patient" has the meaning given that term in ORS 475B.410. (58) "Retailer" means a marijuana retailer licensed by the Commission.

(59) "Safe" means:

(a) A metal receptacle with a locking mechanism capable of storing all marijuana items on a licensed premises that:

(A) Is rendered immobile by being securely anchored to a permanent structure of an enclosed area; or

(B) Weighs more than 750 pounds.

(b) A "vault"; or

(c) A refrigerator or freezer capable of being locked for storing marijuana items that require cold storage that:

(A) Is rendered immobile by being securely anchored to a permanent structure of an enclosed area; or

(B) Weighs more than 750 pounds.

(60) "Sampling laboratory" means a laboratory that only has an ORELAP accredited scope item for sampling under ORS 438.605 to 438.620 and is not accredited to perform cannabis testing.

(61) "Security plan" means a plan as described in OAR 845-025-1030(4)(f) that fully describes how an applicant will comply with applicable laws and rules regarding security.

(62) "Shipping Container" means any container or wrapping used solely for the transport of a marijuana items in bulk to a marijuana licensee as permitted in these rules.

(63) "These rules" means OAR 845-025-1000 to 845-025-8590.

(64) "UID" means unique identification.

(65)(a) "Usable Marijuana" means the dried leaves and flowers of marijuana.

(b) "Usable marijuana" does not include:

(A) The seeds, stalks and roots of marijuana; or

(B) Waste material that is a by-product of producing or processing marijuana.

(66) "Vault" means an enclosed area or room that is constructed of steel-reinforced or block concrete and has a door that contains a multiple-position combination lock or the equivalent, a relocking device or equivalent, and a steel plate with a thickness of at least one-half inch.

(67) "Wholesaler" means a marijuana wholesaler licensed by the Commission.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.015 & 475B.025
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-1030
Application Process

(1) A person may submit an application to the Commission, on a form prescribed by the Commission, for a marijuana producer, processor, wholesaler, retail, or laboratory license.

(2) An application for a license and all documentation required in the application instructions and in section (4) of this rule must be submitted in a manner specified by the Commission. The application fee specified in OAR 845-025-1060 must also be paid in a manner specified by the Commission.

(3) An application must include the names and other required information for all individuals who are applicants as described in OAR 845-025-1045 and who are not applicants but who have a "financial interest" in the business, as defined in OAR 845-025-1015.

(4) Any individual or legal entity with a financial interest who holds or controls an interest of ten percent or greater in the business proposed to be licensed must be identified as an applicant and must submit the documents described in (5)(a)(A) and (B) of this rule.

(5) Applicants must submit the following:

(a) For all individual applicants, all general partners in a limited partnership, limited partners whose investment commitment is ten percent or more of the total investment commitment, all members in a limited liability company or partnership whose investment commitment or membership interest is ten percent or greater, all directors who own or control three percent or more of the voting stock, principal officers of corporate applicants, and all natural person stockholders owning or controlling ten percent or more of the voting stock of corporate entity

(A) Information or fingerprints for a criminal background check in accordance with OAR 845-025-1080;

(B) Any forms required by the Commission and any information identified in the form that is required to be submitted; and

(b) A map or sketch of the premises proposed for licensure, including the defined boundaries of the premises and the location of any primary residence located on the same lot or parcel as the licensed premises;

(c) A scaled floor or plot plan sketch of all enclosed areas with clear identification of walls, partitions, counters, windows, all areas of ingress and egress, and all limited access areas;

(d) Proof of right to occupy the premises proposed for licensure;

(e) An operating plan that demonstrates at a minimum, how the applicant's proposed premises and business will comply with the applicable laws and rules regarding:

(A) Security;

(B) Employee qualifications and training;

(C) Transportation of product;

(D) Preventing minors from entering the licensed premises; and

(E) Preventing minors from obtaining or attempting to obtain marijuana items.

(f) For producers:

(A) The proposed canopy size and tier as described in OAR 845-025-2040 and a designation of the canopy area within the license premises.

(B) A report describing the applicant's electricity and water usage, on a form prescribed by the Commission.

(i) For initial licensure and renewal, the report must describe the estimated electricity and water usage taking into account all portions of the premises and expected requirements of the operation for the next twelve months.

(ii) In addition to requirements of section (4)(f)(B)(i), for renewal, the report must describe the actual electricity and water usage for the previous year taking into account all portions of the premises.

(C) A description of the growing operation including growing media, a description of equipment to be used in the production, and whether production will be indoor, outdoor or both.

(D) Proof of a legal source of water as evidenced by:

(i) A copy of a water right permit, certificate, or other water use authorization from the Oregon Water Resources Department;

(ii) A statement that water is supplied from a public or private water provider, along with the name and contact information of the water provider; or

(iii) Proof from the Oregon Water Resources Department that the water to be used for production is from a source that does not require a water right.

(g) For processors:

(A) On a form prescribed by the Commission, the proposed endorsements as described in OAR 845-025-3210.

(B) A description of the type of products to be processed, a description of equipment to be used, including any solvents, gases, chemicals or other compounds used to create extracts or concentrates.

(5) In addition to submitting the application form and the items described in (4) of this rule the Commission may require the following to be submitted:

(a) For an individual identified as a person with a financial interest, who holds or controls an interest of less than ten percent in the business proposed to be licensed:

(A) Information or fingerprints for a criminal background check in accordance with OAR 845-025-1080;

(B) Any forms required by the Commission and any information identified in the form that is required to be submitted;

(b) For a legal entity that is identified as having a financial interest of less than ten percent of the business proposed to be licensed:

(A) Information or fingerprints for any individual within the legal entity for a criminal background check in accordance with OAR 845-025-1080;

(B) Any forms required by the Commission and any information identified in the form that is required to be submitted; and

(c) Any additional information if there is a reason to believe that the information is needed to determine the merits of the license application.

(6) The Commission must review an application to determine if it is complete. An application will be considered incomplete if an application form is not complete, the full application fee has not been paid, or some or all of the additional information required under sections (4) and (5) of this rule is not submitted.

(7) An applicant may submit a written request for reconsideration of a decision that an application is incomplete. Such a request must be received by the Commission within ten days of the date the incomplete notice was mailed to the applicant. The Commission shall give the applicants the opportunity to be heard if an application is rejected. A hearing under this subsection is not subject to the requirements for contested case proceedings under ORS 183.310 to 183.550.

(8) If, prior to an application being acted upon by the Commission, there is a change with regard to who is an applicant or who is a person with a financial interest in the proposed business, the new applicant or person with a financial interest must submit a form, prescribed by the Commission, that:

(a) Identifies the individual or person;

(b) Describes the individual's or person's financial interest in the business proposed for licensure; and

(c) Includes any additional information required by the Commission, including but not limited to information and fingerprints required for a criminal background check.

(9) Failure to comply with subsection (6) of this rule may result in an application being denied.

Stat. Auth.: ORS 475B.025 & 2016 OL Ch. 24, Sec. 1, 17 & 18
Stats. Implemented: ORS 475B.040, 475B.045, 475B.060, 475B.070, 475B.090, 475B.100, 475B.110 & 475B.560
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-1045
Qualifications of an Applicant

(1) True name on application. An application for a license must specify the real and true names of all individuals and legal entities that have an ownership interest in the business proposed to be licensed by identifying all such persons and legal entities as applicants.

(2) License privileges. License privileges are available only to the applicants identified in the application and their authorized representatives and only for the premises designated on the license.

(3) Ownership interest. The Commission may refuse to issue a license if the applicant is not the owner of the business proposed to be licensed or an undisclosed ownership interest exists. For purposes of this rule, an "ownership interest" is indicated by the following behaviors, benefits or obligations:

(a) Any person or legal entity, other than an employee acting under the direction of the owner, that exercises control over, or is entitled to exercise control over, the business;

(b) Any person or legal entity, other than an employee acting under the direction of the owner, that incurs, or is entitled to incur, debt or similar obligations on behalf of the business;

(c) Any person or legal entity, other than an employee acting under the direction of the owner, that enters into, or is entitled to enter into, a contract or similar obligations on behalf of the business; or

(d) Any person or legal entity identified as the lessee of the premises proposed to be licensed.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.045, 475B.070, 475B.090, 475B.100, 475B.110, 475B.560 & 2016 OL Ch. 24, Sec. 1, 2, 3 & 4
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-1060
Fees

(1) At the time of initial license or certificate application an applicant must pay a $250 non-refundable application fee.

(2) If the Commission approves an application and grants an annual license, the following fees must be paid, prorated for an initial license that is issued for six months or less:

(a) Producers:

(A) Micro Tier I $1,000.

(B) Micro Tier II $2,000.

(C) Tier I $3,750.

(D) Tier II $5,750.

(b) Processors: $4,750.

(c) Wholesalers: $4,750.

(d) Micro Wholesalers: $1,000.

(e) Retailers: $4,750.

(f) Laboratories: $4,750.

(g) Sampling Laboratory: $2,250.

(3) If the Commission approves an application and grants a research certificate, the fee is $4,750 for a three-year term.

(4) At the time of license or certificate application renewal, an applicant must pay a $250 non-refundable application fee.

(5) If the Commission approves a renewal application the renewal license or certificate fees must be paid in the amounts specified in subsections (2) and (3) of this rule.

(6) If the Commission approves an initial or renewal application and grants a marijuana worker permit, the individual must pay a $100 permit fee.

(7) The Commission shall charge the following fees:

(a) Criminal background checks: $50 per individual listed on a license application (if the background check is not part of an initial or renewal application)

(b) Change of ownership review: $1000 per license.

(c) Change in business structure review: $1000 per license.

(d) Transfer of location of premises review: $1000 per license.

(e) Packaging preapproval: $100.

(f) Labeling preapproval: $100.

(g) Change to previously approved package or label: $25.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.025, 475B.070, 475B.090, 475B.100, 475B.110, 475B.218, 475B.560, 475B.610 & 475B.620, & 2016 OL Ch. 24 Sec. 1
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-1090
Application Review

(1) Once the Commission has determined that an application is complete it must review the application to determine compliance with ORS Chapter 475B and these rules.

(2) The Commission:

(a) Must, prior to acting on an application, receive a land use compatibility statement from the city or county that authorizes land use in the city or county in which the applicant's proposed premises is located.

(b) May, in its discretion, prior to acting on an application:

(A) Contact any applicant or individual with a financial interest and request additional documentation or information; and

(B) Verify any information submitted by the applicant.

(3) The requirements of section (2)(a) of this rule do not apply to applicants for a producer license if the applicant demonstrates in a form and manner specified by the Commission that:

(a) The applicant is applying for a license at an address where a marijuana grow site registered under ORS 475B.420 is located;

(b) The address is outside of city limits;

(c) At least one person responsible for a marijuana grow site located at the address first registered with the Authority under ORS 475B.420 before January 1, 2015;

(d) Each person responsible for a marijuana grow site located at the address first registered with the Authority under ORS 475B.420 before February 1, 2016; and

(e) The applicant is applying for a mature marijuana plant grow canopy of:

(A) 5,000 square feet or less, if the marijuana is produced outdoors; or

(B) 1,250 square feet or less, if the marijuana is produced indoors.

(4) The Commission must inspect the proposed premises prior to issuing a license.

(5) If during an inspection the Commission determines the applicant is not in compliance with these rules, the applicant will be provided with a notice of the failed inspection and the requirements that have not been met.

(a) An applicant that fails an inspection will have 15 calendar days from the date the notice was sent to submit a written response that demonstrates the deficiencies have been corrected.

(b) An applicant may request in writing one extension of the 15-day time limit in subsection (a) of this section, not to exceed 30 days.

(6) If an applicant does not submit a timely plan of correction or if the plan of correction does not correct the deficiencies in a manner that would bring the applicant into compliance, the Commission may deny the application.

(7) If the plan of correction appears, on its face, to correct the deficiencies, the Commission will schedule another inspection.

(8) If an applicant fails a second inspection, the Commission may deny the application unless the applicant shows good cause for the Commission to perform additional inspections.

Stat. Auth.: ORS 475B.025
Stats. Implemented: ORS 475B.045, 475B.285, 475B.063 & 2016 OL Ch. 23, Sec. 2
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-1115
Denial of Application

(1) The Commission must deny an initial or renewal application if:

(a) An applicant is under the age of 21.(b) The applicant's land use compatibility statement shows that the proposed land use is prohibited in the applicable zone, if a land use compatibility statement is required.

(c) The proposed licensed premises is located:

(A) On federal property.

(B) On reservation or tribal trust land of a federally recognized Indian tribe unless that tribe has entered into an agreement with the State of Oregon which allows licensing of recreational marijuana businesses.

(d) The proposed licensed premises of a producer is located on the same lot or parcel, as those terms are defined in ORS 92.010, as a site registered with Oregon Department of Agriculture for the production of industrial hemp, unless the applicant submits and the Commission approves a control plan describing how the registered site will be separated from the premises proposed to be licensed and how the applicant will prevent transfer of industrial hemp to the licensed premises.

(e) The proposed licensed premises of a processor who has applied for an endorsement to process extracts is located in an area that is zoned exclusively for residential use.

(f) The proposed licensed premises of a retail applicant is located:

(A) Except as provided in Oregon Laws 2016, chapter 83, section 29b, within 1,000 feet of:

(i) A public elementary or secondary school for which attendance is compulsory under ORS 339.020; or

(ii) A private or parochial elementary or secondary school, teaching children as described in ORS 339.030.

(B) In an area that is zoned exclusively for residential use.

(g) The proposed licensed premises of a wholesaler applicant is in an area zoned exclusively for residential use.

(h) A city or county has prohibited the license type for which the applicant is applying, in accordance with ORS 475B.800.

(2) The Commission may deny an initial or renewal application, unless the applicant shows good cause to overcome the denial criteria, if it has reasonable cause to believe that:

(a) The applicant:

(A) Is in the habit of using alcoholic beverages, habit-forming drugs, marijuana, or controlled substances to excess.

(B) Has made false statements to the Commission.

(C) Is incompetent or physically unable to carry on the management of the establishment proposed to be licensed.

(D) Is not of good repute and moral character.

(E) Does not have a good record of compliance with ORS 475B.010 to 475B.395, or these rules, prior to or after licensure including but not limited to:

(i) The giving away of marijuana items as a prize, premium or consideration for a lottery, contest, game of chance or skill, or competition of any kind, in violation of ORS 475B.275;

(ii) Providing marijuana items to an individual without checking that the individual is 21 or older;

(iii) Unlicensed transfer of marijuana items for financial consideration; or

(iv) Violations of local ordinances adopted under ORS 475B.340, pending or adjudicated by the local government that adopted the ordinance.

(F) Is not possessed of or has not demonstrated financial responsibility sufficient to adequately meet the requirements of the business proposed to be licensed.

(G) Is unable to understand the laws of this state relating to marijuana or these rules, including but not limited to ORS 475.300 to 475.346 and ORS 475B.550 to 475B.590. Inability to understand laws and rules of this state related to marijuana may be demonstrated by violations documented by the Oregon Health Authority.

(b) Any individual listed on the application has been convicted of violating a general or local law of this state or another state, or of violating a federal law, if the conviction is substantially related to the fitness and ability of the applicant to lawfully carry out activities under the license, except as specified in ORS 475B.045(3).

(c) Any applicant is not the legitimate owner of the business proposed to be licensed, or other persons have an ownership interest in the business have not been disclosed to the Commission.

(d) The business proposed to be licensed is located at the same physical location or address as a premises licensed under ORS Chapter 471 or as a retail liquor agent appointed by the Commission.

(e) The proposed licensed premises of a producer applicant is on the same lot or parcel, as those terms are defined in ORS 92.010, as another producer licensee under common ownership.

(f) The proposed licensed premises of a producer applicant is on the same lot or parcel, as those terms are defined in ORS 92.010, as another producer licensee under diverse ownership if the Commission reasonably believes that the presence of multiple producers on the same lot or parcel creates a compliance risk or other risk to public health and safety.

(3) The Commission may refuse to issue a license to any license applicant or refuse to renew the license of any licensee when conditions exist in relation to any person having a financial interest in the business or in the place of business which would constitute grounds for refusing to issue a license or for revocation or suspension of a license if such person were the license applicant or licensee.

(4) The Commission may deny any initial or renewal application and may revoke any license if medical marijuana items are produced, processed, stored, sold or transported, to or from the same address or location of licensed business or business proposed to be licensed.

(a) The Commission will not deny an initial application under this subsection if:

(A) The applicant surrenders any registration issued by the Authority for the address or location of the business proposed to be licensed;

(B) If applicable, the applicant notifies all other growers registered by the Authority at the location or address proposed to be licensed, in a form and manner prescribed by the Commission, that the grower is no longer permitted to produce medical marijuana at the address or location proposed to be licensed and must surrender his or her registration at that address or location; and

(C) All medical marijuana activity at the location or address proposed to be licensed ceases prior to being issued an OLCC license.

(5) If the Commission denies an application because an applicant submitted false or misleading information to the Commission, the Commission may prohibit the applicant from re-applying for five years.

(6) A notice of denial must be issued in accordance with ORS 183.

Stat. Auth.: ORS 475B.025

Stats. Implemented: ORS 475B.040, 475B.045, 475B.063, 475B.070, 475B.090, 475B.100, 475B.110, 475B.560, 475B.800, 2016 OL Ch. 24, Sec. 1 & 2016 OL Ch. 83, Sec. 29b

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2015(Temp), f. 12-22-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-2020

Producer Privileges; Prohibitions

(1) A producer may:

(a) Plant, cultivate, grow, harvest and dry marijuana in the manner approved by the Commission and consistent with ORS 475B and these rules;

(b) Engage in indoor or outdoor production of marijuana, or a combination of the two;

(c) Sell or transport:

(A) Usable marijuana to the licensed premises of a marijuana processor, wholesaler, retailer, laboratory, non-profit dispensary, or research certificate holder;

(B) Whole, non-living marijuana plants that have been entirely removed from any growing medium to the licensed premises of a marijuana processor, wholesaler, non-profit dispensary or research certificate holder;

(C) Immature marijuana plants and seeds to the licensed premises of a marijuana producer, wholesaler, retailer or research certificate holder;

(D) Marijuana waste to a producer, processor, wholesaler, or research certificate holder.

(d) Purchase and receive:

(A) Immature marijuana plants and seeds from a producer, wholesaler, or research certificate holder; and

(B) Marijuana waste from a producer, processor, wholesaler, retailer, laboratory, or research certificate holder.

(C) Usable marijuana produced by the licensee that has been stored by a wholesaler on the producer's behalf.

(e) Allow a laboratory licensee to obtain samples for purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490.

(2) A producer may not sell, deliver, purchase, or receive any marijuana item other than as provided in section (1) of this rule.

(3) No industrial hemp may be present on a producer's licensed premises. Violation of this section is a Category I violation.

Stat. Auth.: ORS 475B.025, 475B.070 & 475B.075

Stats. Implemented: ORS 475B.025, 475B.070, 475B.075, 2016 OL Ch. 23, Sec. 24 & 2016 OL Ch. 24, Sec. 12 & 65

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-2030

Licensed Premises of Producer

The licensed premises of a producer includes all public and private areas used in the business operated at the location(2) A producer may not engage in any privileges of the license within a residence.

Stat. Auth.: ORS 475B.025 & 475B.070

Stats. Implemented: ORS 475B.070, 475B.080 & 2016 OL, Ch. 24, Sec. 63

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-2060

Start-up Inventory

(1) Marijuana producers may not receive immature marijuana plants or seeds from any source other than from another licensee, except:

(a) Between January 1, 2016 and December 31, 2017 a marijuana producer may receive immature marijuana plants and seeds from any source within Oregon for up to 90 days following initial licensure by the Commission.

(b) Pursuant to the transfer of medical marijuana inventory under OAR 845-025-2100.

(2) The marijuana producer shall, through CTS, report receipt of the number of immature marijuana plants or seeds received under this section within 24 hours of the plants or seeds arriving at the licensed premises. A producer does not have to document the source of the immature plants or seeds during the 90 day start-up period.

(3) The requirements in section (2) of this rule do not apply during the first ten calendar days of licensure so long as the licensee has ordered UID tags and the UID tags are in transit to the licensee.

(4) Failure to comply with this rule is a Category I violation and could result in license revocation.

Stat. Auth.: ORS 475B.025 & 475B.070
Stats. Implemented: ORS 475B.023, 475B.070 & 2016 OL Ch. 24, Sec. 25
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-2100
Transfer of Medical Marijuana Grower Inventory

(1) An individual applicant listed on an application for a producer license under ORS 475B.070 that is also a PRMG may submit a transfer request to the Commission, on a form prescribed by the Commission, to transition a medical marijuana grow site from being registered with the Authority to being licensed by the Commission. The request must include, at a minimum, the following information:

(a) The names, contact information, and Authority issued registry identification number for each PRMG currently registered at the grow site address that is the proposed premises to be licensed;

(b) The number of patients each PRMG is producing marijuana for at the grow site address that is the proposed premises to be licensed.

(c) Copies of all personal agreements entered into under ORS 475B.425 that specify whether a patient has authorized the transfer of marijuana plants or usable marijuana to the Commission license and if so, how much may be transferred.

(d) An authorization that permits the Authority to disclose to the Commission the PRMG's registration information.

(2) Upon receipt of a request under section (1) of this rule the Commission must verify with the Authority:

(a) The registration status of each PRMG identified in the transfer request;

(b) The number of PRMGs registered at the grow site address that is the proposed premises to be licensed; and

(c) The number of patients each PRMG is producing marijuana for at that grow site address.

(3) The Commission will deny a transfer request if an applicant has not complied with this rule or if a license is denied under OAR 845-025-1115.

(4) If the information in the transfer request is verified by the Authority and the Commission approves a license application under ORS 475B.070, the Commission must notify the applicant of the number of seeds, marijuana plants and usable marijuana permitted to be transferred. Information regarding the seeds, marijuana plants and usable marijuana transferred must be recorded in CTS within ten calendar days of licensure.

(a) The number of marijuana plants and amount of usable marijuana that is permitted to be transferred will be based on the number of patients whose registration status has been verified by the Authority in accordance with section (2) of this rule and who have authorized the transfer of marijuana items to the Commission license.

(b) There is no limit on seeds or immature plants that may be transferred to the Commission license, subject to subsection (a) of this section.

(c) No more than six mature plants per patient may be transferred to the Commission license, subject to subsection (a) of this section.

(c) No more than 24 ounces of usable marijuana per patient may be transferred to the Commission license, subject to subsection (a) of this section.

(d) Any seeds, marijuana plants or usable marijuana that exceed the amount permitted by the Commission to be transferred must be removed from the premises by the applicant prior to the initial date of licensure and lawfully transferred or disposed of.

(5) The licensee must notify the Commission once the marijuana plants and usable marijuana are entered into CTS and the Commission may inspect the premises to verify the information the licensee entered into CTS.

(6) Once the transfer of inventory under this section is complete the Commission must notify the Authority that the grow site address is now a licensed premises and that the licensed premises may not be registered as a grow site address under ORS 475B.420.

(7) The Commission may deny a transfer request if it cannot verify the information in the request or if the applicant submits incomplete information to the Commission.

(8) Any usable marijuana transferred from a medical marijuana grow site to the licensed premises under this rule must be tested, labeled and packaged, in accordance with OAR 845-025-7000 to 845-025-7060 and 845-025-5700 as applicable, before transferring the usable marijuana to another licensee.

Stat. Auth.: ORS 475B.025 & 475B.070
Stats. Implemented: 2016 OL Ch. 24, Sec. 25
Hist.: OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-2800
Retailer Privileges; Prohibitions

(1) A retailer is the only licensee that is authorized to sell a marijuana item to a consumer.

(2) A retailer may:

(a) Between the hours of 7:00 AM and 10:00 PM local time, sell marijuana items from the licensed premises to a consumer 21 years of age or older;

(b) Sell and deliver:

(A) Marijuana items to a consumer 21 years of age or older pursuant to a bona fide order as described in OAR 845-025-2880.

(B) Marijuana waste to a producer, processor, wholesaler, or research certificate holder.

(C) Return marijuana items to a producer, processor or wholesaler who transferred the item to the retailer.

(c) Purchase and receive:

(A) Usable marijuana, immature marijuana plants, and seeds from a producer or research certificate holder;

(B) Cannabinoid concentrates, extracts, and products from a processor with an endorsement to manufacture the type of product received or a research certificate holder;

(C) Any marijuana item from a wholesaler;

(D) Any marijuana item from a laboratory; and

(d) Refuse to sell marijuana items to a consumer; and

(e) Allow a laboratory licensee to obtain samples for purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490.

(3) A retailer may not:

(a) Sell more than the following amounts to a consumer at any one time or within one day:

(A) One ounce of usable marijuana;

(B) 16 ounces of a cannabinoid product in solid form;

(C) 72 ounces of a cannabinoid product in liquid form;

(D) Five grams of cannabinoid extracts or concentrates, whether sold alone or contained in an inhalant delivery system;

(E) Four immature marijuana plants; and

(F) Ten marijuana seeds.

(b) Provide free marijuana items to a consumer.

(c) Sell or give away pressurized containers of butane or other materials that could be used in the home production of marijuana extracts.

(d) Discount a marijuana item if the retail sale of the marijuana is made in conjunction with the retail sale of any other items, including other marijuana items.

(e) Sell a marijuana item at a nominal price for promotional purposes.

(f) Permit consumers to be present on the licensed premises or sell to a consumer between the hours of 10:00 p.m. and 7:00 a.m. local time the following day.

(g) Sell any product derived from industrial hemp, as that is defined in ORS 571.300, that is intended for human consumption, ingestion, or inhalation, unless it has been tested, labeled and packaged in accordance with the applicable sections of these rules.

(h) Permit a licensed representative to handle an unpackaged marijuana item without the use of protective gloves, tools or instruments that prevent the marijuana item from coming into contact with the license representative's skin.

(i) Sell, transfer, deliver, purchase, or receive any marijuana item other than as provided in section (2) of this rule.

Stat. Auth.: ORS 475B.025 & 475B.110
Stats. Implemented: ORS 475B.025, 475B.110 & 2016 OL Ch. 24, Sec. 12 & 65
Stat. Auth.: ORS 475B.025 & 475B.110
Stats. Implemented: ORS 475B.025 & 475B.110
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-2840
Retailer Premises

(1) The licensed premises of a retailer:

(a) May not be located in an area that is zoned exclusively for residential use.

(b) Except as provided in Oregon Laws 2016, chapter 83, section 29b, may not be located within 1,000 feet of:

(A) A public elementary or secondary school for which attendance is compulsory under ORS 339.020; or

(B) A private or parochial elementary or secondary school, teaching children as described in ORS 339.030.

(c) Must be enclosed on all sides by permanent walls and doors.

(2) A retailer must post in a prominent place signs at every:

(a) Point of sale that read:

(A) "No Minors Permitted Anywhere on the Premises"; and

(B) "No On-Site Consumption".

(b) Exit from the licensed premises that reads: "Marijuana or Marijuana Infused Products May Not Be Consumed In Public".

(3) A retailer must designate a consumer sales area on the licensed premises where consumers are permitted. The area shall include the portion of the premises where marijuana items are displayed for sale to the consumer and sold and may include other contiguous areas such as a lobby or a restroom. The consumer sales area is the sole area of the licensed premises where consumers are permitted.

(4) All inventory must be stored on the licensed premises.

(5) For purposes of determining the distance between a retailer and a school referenced in subsection (1)(b) of this rule, "within 1,000 feet" means a straight line measurement in a radius extending for 1,000 feet or less in any direction from the closest point anywhere on the boundary line of the real property comprising a school to the closest point of the licensed premises of a retailer. If any portion of the licensed premises is within 1,000 feet of a school as described subsection (1)(b) of this rule an applicant will not be licensed.

Stat. Auth.: ORS 475B.025 & 475B.110
Stats. Implemented: ORS 475B.110, 475B.160 & 2016 OL Ch. 83, Sec. 29b
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-2900
Retail Sale of Marijuana for Medical Purposes

(1) In order to sell marijuana items for medical purposes a marijuana retailer licensed under ORS 475B.110 must register in a form and manner specified by the commission.

(2) A marijuana retailer licensed under ORS 475B.110 who has registered with the commission to sell marijuana items for medical purposes, may:

(a) Sell marijuana items tax free to registry identification cardholders and designated primary caregivers.

(b) Sell medical grade cannabinoid product, cannabinoid concentrate or extract to registry identification cardholders and designated primary caregivers.

(c) May sell or provide usable marijuana and medical grade cannabinoid products, concentrates and extracts to registry identification cardholders and designated primary caregivers free of charge or at a discounted price.

(d) Notwithstanding the requirements of OAR 845-025-1230, 845-025-2800, 845-025-2820 and 845-025-8520, may permit registry identification cardholders 18 years of age and older to be present on the licensed premises and purchase marijuana items.

(3) A marijuana retailer who has registered with the commission to sell marijuana items for medical purposes must:

(a) Store and display medical grade cannabinoid products, concentrates and extracts in a manner that separates medical grade items from other marijuana items.

(b) Comply with the requirements of OAR 333-007-0100 to 333-007-0100 for labeling medical grade products.

(c) Verify the individual who is purchasing a marijuana item for medical purposes is currently registered with the Authority by viewing the individual's government issued photo identification and Authority issued registry identification card or designated primary care giver card, or a receipt issued by the Authority under OAR 333-008-0023 or 333-008-0040 and making sure the identities match and that the card is current or the receipt has not expired, prior to the sale or transfer of a marijuana item as described in section (2) of this rule.

(d) Use CTS to record the receipt or card number of every registry identification cardholder and designated primary care giver who receives marijuana items as described in section (2) of this rule together with the date of the sale or transfer and amount sold or transferred.

(4) Violation of this rule is a category III violation.

Stat. Auth.: ORS 475B.025
Stats. Implemented: 2016 OL Ch. 83, Sec. 5
Hist.: OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-2910
Transfer of Medical Marijuana Dispensary Inventory

(1) For purposes of this rule:

(a) "Medical marijuana dispensary" means a medical marijuana dispensary registered under ORS 475B.450.

(b) "Person responsible for the medical marijuana dispensary" or "PRD" has the meaning given that term in OAR 333-008-1010.

(c) "Primary PRD" has the meaning given that term in OAR 333-008-1010.

(2) An applicant for a retail license under ORS 475B.110 that is also an owner of a medical marijuana dispensary may submit a transfer request to the Commission, on a form prescribed by the Commission, to transition from being registered with the Authority to being licensed by the Commission. The request must include, at a minimum, the following information:

(a) The name of the marijuana dispensary, dispensary address, and Authority issued registration number for the medical marijuana dispensary;

(b) The name and contact information of the owner of the medical marijuana dispensary;

(c) The names and contact information for each PRD;

(d) Identification of the primary PRD.

(e) An authorization that permits the Authority to disclose to the Commission any information necessary to verify the information submitted in the request.

(f) The amount and type of marijuana items proposed to be transferred.

(3) Upon receiving a request under section (2) of this rule the Commission must verify with the Authority:

(a) The registration status of the medical marijuana dispensary; and

(b) The ownership of the dispensary and the identification of each PRD and the primary PRD;

(4) A transfer request will be denied if an applicant has not complied with this rule or if a license is denied under OAR 845-025-1115.

(5) The Commission may inspect the marijuana items proposed for transfer to determine if they:

(a) Have been packaged, labeled and tested in accordance with OAR 845-025-7000 to 845-025-7060 and 845-025-5700; and

(b) Meet the applicable concentration limits in OAR 333-007-0210 or 333-007-0220.

(6) If the information in the transfer request is verified by the Authority and the Commission approves a license application under ORS 475B.090, the Commission must notify the applicant of the amount and type of marijuana items permitted to be transferred.

(a) The Commission will deny the request to transfer any marijuana item that:

(A) Was not identified in the request to transfer;

(B) Was not in the dispensary's inventory at the time of the request to transfer; and

(C) Does not comply with the applicable packaging, labeling and testing rules in OAR 845-025-7000 to 845-025-7060 and 845-025-5700.

(b) The Commission may not permit the transfer of a cannabinoid concentrate, extract or product that exceeds the concentration limits established for retail adult use under OAR 333-007-0210 unless the licensee has been registered to sell medical grade cannabinoid concentrates, extracts or products.

(c) Any marijuana items that have not been approved for transfer must be lawfully disposed of and removed from the premises prior to the initial date of licensure.

(7) Information regarding the seeds, immature plants, usable marijuana, cannabinoid concentrates, extracts or products transferred must be recorded in CTS within ten calendar days of licensure.

(8) The licensee must notify the Commission once the seeds, immature plants, usable marijuana, cannabinoid concentrates, extracts or products are entered into CTS and the Commission may inspect the premises to verify the information the licensee entered into CTS.

(9) Once the transfer of inventory under this section is complete the Commission must notify the Authority that the medical marijuana dispensary is now a licensed premises and that the licensed premises may not be registered as a medical marijuana dispensary address under ORS 475B.450.

(10) The Commission may deny a transfer request if it cannot verify the information in the request or the applicant submitted incomplete information to the Commission.

Stat. Auth.: ORS 475B.025
Stats. Implemented: 2016 OL Ch. 24, Sec. 25
Hist.: OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-3215
Processor Privileges; Prohibitions

(1) A processor may:

(a) Transfer, sell or transport:

(A) Cannabinoid concentrates, extracts, and products for which the processor has an endorsement to a processor, wholesaler, retailer, non-profit dispensary, or research certificate holder; and

(B) Marijuana waste to a producer, processor, wholesaler, or research certificate holder.

(b) Purchase and receive:

(A) Whole, non-living marijuana plants that have been entirely removed from any growing medium from a producer, wholesaler, or research certificate holder;

(B) Usable marijuana from a producer, wholesaler, or research certificate holder;

(C) Cannabinoid concentrates, extracts and products from a processor with an endorsement to manufacture the type of product received, or research certificate holder;

(D) Marijuana waste from a producer, processor, wholesaler, retailer, laboratory, or research certificate holder; and

(E) Cannabinoid concentrates, extracts, and products produced by the licensee that have been held in bailment by a wholesaler.

(c) Allow a laboratory licensee to obtain samples for purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490.

(2) A processor may not transfer, sell transport, purchase, or receive any marijuana item other than as provided in section (1) of this rule.

Stat. Auth.: ORS 475B.025 & 475B.090, 2016 OL Ch. 23, Sec. 24 & 2016 OL Ch. 24, Sec. 12 & 65
Stats. Implemented: ORS 475B.025 & 475B.090
Hist.: OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-3300
Processing Marijuana for Medical Purposes

(1) In order to process marijuana items for medical purposes a marijuana processor licensed under ORS 475B.090 must register with the commission in a form and manner specified by the commission.

(2) A marijuana processor licensed under ORS 475B.090 who has registered with the commission to process marijuana items for medical purposes:

(a) May:

(A) Process medical grade cannabinoid products, concentrates or extracts; and

(B) Sell medical grade cannabinoid products, concentrates or extracts to wholesalers, processors and retailers who have registered to sell or process marijuana for medical purposes.

(b) Must comply with the requirements of OAR 333-007-0100 to 333-007-0100 for labeling medical grade products.

Stat. Auth.: ORS 475.025
Stats. Implemented: 2016 OL Ch. 83, Sec. 3
Hist.: OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-3310
Transfer of Medical Marijuana Processing Site Inventory

(1) For purposes of this rule:

(a) "Marijuana processing site" means a marijuana processing site registered under ORS 475B.435.

(b) "Person responsible for the marijuana processing site" or "PRP" has the meaning given that term in OAR 333-008-0160.

(c) "Primary PRP" has the meaning given that term in OAR 333-008-0160.

(2) An applicant for a processor license under ORS 475B.090 that is also an owner of a marijuana processing site may submit a transfer request to the Commission, on a form prescribed by the Commission, to transition from being registered with the Authority to being licensed by the Commission. The request must include, at a minimum, the following information:

(a) The name of the marijuana processing site, address, and Authority issued registration number for the marijuana processing site;

(b) The name and contact information of the owner of the marijuana processing site;

(c) The names and contact information for each PRP;

(d) Identification of the primary PRP.

(e) The endorsements of the marijuana processing site.

(f) An authorization that permits the Authority to disclose to the Commission any information necessary to verify the information submitted in the request.

(g) The amount and types of marijuana items proposed to be transferred.

(3) Upon receiving a request under section (2) of this rule the Commission must verify with the Authority:

(a) The registration status of the marijuana processing site; and

(b) The ownership of the processing site and the identification of each PRP and the primary PRP;

(4) A transfer request will be denied if an applicant has not complied with this rule or if a license is denied under OAR 845-025-1115.

(5) If the information in the transfer request is verified by the Authority and the Commission approves a license application under ORS 475B.090, the Commission must notify the applicant of the amount and type of marijuana items permitted to be transferred.

(a) The Commission may not permit the transfer of a marijuana cannabinoid product, concentrate or extract packaged for ultimate sale to the consumer that exceeds the concentration limits established for retail adult use under OAR 333-007-0210 unless the licensee has been registered to process medical grade cannabinoid concentrates, extracts or products.

(b) Prior to licensure the marijuana processing site must return any marijuana item that is the lawful property of a patient.

(c) Any marijuana items that have not been approved by the Commission for transfer or returned to a patient as described in section (5)(b) of this rule must be removed from the premises by the applicant prior to the initial date of licensure and lawfully transferred or disposed of.

(6) Information regarding the usable marijuana, cannabinoid concentrates, extracts or products transferred must be recorded in CTS within ten calendar days of licensure.

(7) The licensee must notify the Commission once the usable marijuana, cannabinoid concentrates, extracts or products are entered into CTS and the Commission may inspect the premises to verify the information the licensee entered into CTS.

(8) Once the transfer of inventory under this section is complete the Commission must notify the Authority that the marijuana processing site is now a licensed premises and that the licensed premises may not be registered as a marijuana processing site address under ORS 475B.435.

(9) The Commission may deny a transfer request if:

(a) It cannot verify the information in the request or the applicant submitted incomplete information to the Commission; or

(b) The processor has not been granted an endorsement for the type of marijuana item requested for transfer.

(10) Any usable marijuana, cannabinoid concentrates, extracts or products transferred from a medical marijuana processing site to the licensed premises under this rule must be:

(a) Tested in accordance with OAR 845-025-5700 before being used or transferred; and

(b) Labeled and packaged in accordance with OAR 845-025-7000 to 845-025-7060 before being transferred to another licensee.

Stat. Auth.: ORS 475.025
Stats. Implemented: 2016 OL Ch. 24, Sec. 25
Hist.: OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-3500
Wholesale License Privileges; Prohibitions

(1) A wholesale licensee may:

(a) Sell, including sale by auction, transfer and transport:

(A) Any type of marijuana item to a retailer, wholesaler, non-profit dispensary or research certificate holder;

(B) Immature marijuana plants and seeds to a producer;

(C) Usable marijuana to a producer license that the wholesale license has stored on the producer's behalf;

(D) Usable marijuana, cannabinoid extracts and concentrates to a processor licensee; and

(E) Marijuana waste to a producer or processor or research certificate holder.

(b) Purchase or receive:

(A) Any type of marijuana item from a wholesaler.

(B) Cannabinoid concentrates, extracts, and products from a processor with an endorsement to manufacture the type of product received;

(C) Seeds, immature plants or usable marijuana from a producer;

(D) Whole, non-living marijuana plants that have been entirely removed from any growing medium from a producer; and

(E) Marijuana waste from a producer, processor, wholesaler, retailer, laboratory, or research certificate holder.

(c) Transport and store marijuana items on behalf of other licensees, pursuant to the requirements of OAR 845-025-7500 to OAR 845-025-7590.

(d) Allow a laboratory licensee to obtain samples for purposes of performing testing as provided in these rules and OAR 333-007-0300 to 333-007-0490.

(2) A wholesale licensee may not sell, deliver, purchase, or receive any marijuana item other than as provided in section (1) of this rule.

(3) For purposes of this rule, "marijuana item" does not include a mature marijuana plant.

Stat. Auth.: ORS 475B.025 & 475B.090

Stats. Implemented: ORS 475B.100 & 475B.400 & 2016, OL Ch. 23, Sec. 24

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-3510

Micro-Wholesaler License Privileges

A micro-wholesale licensee has all the license privileges in OAR 845-025-3500 except that the licensee may only receive marijuana items from a producer with a micro tier I or tier II canopy.

Stat. Auth.: ORS 475B.025 & 475B.075

Stats. Implemented: ORS 475B.075 & 2016 OL Ch. 24, Sec. 1

Hist.: OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-3600

Wholesaling Marijuana for Medical Purposes

(1) In order to sell marijuana at wholesale for medical purposes a marijuana wholesaler licensed under ORS 475B.100 must register with the commission in a form and manner specified by the commission.

(2) A marijuana wholesaler licensed under ORS 475B.100 who has registered with the commission to wholesale marijuana items for medical purposes:

(a) May:

(A) Receive or purchase medical grade cannabinoid products, concentrates or extracts from processors that have registered to process marijuana items for medical purposes; and

(B) Sell or transfer medical grade cannabinoid products, concentrates or extracts to wholesalers, processors and retailers who have registered to sell or process marijuana for medical purposes.

(b) Must comply with the requirements of OAR 333-007-0100 to 333-007-0100 for labeling medical grade products.

Stat. Auth.: ORS 475B.025

Stats. Implemented: ORS 475B.075 & 2016 OL Ch. 83, Sec. 4

Hist.: OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-5000

Laboratory License Privileges; Requirements

(1) A licensed marijuana testing laboratory may:

(a) Obtain samples of marijuana items from licensees or registrants for the purpose of testing as provided in these rules and OAR 333-007-0300 to 333-007-0490 if the laboratory has an accredited scope item for sampling;

(b) Transport and dispose of samples as provided in these rules;

(c) Perform testing on marijuana items in a manner consistent with the laboratory's accreditation by the Authority, these rules, OAR 333-007-0300 to 333-007-0490, and OAR 333, division 64; and

(d) Transfer the laboratory's marijuana waste to a producer, processor, wholesaler, or research certificate holder.

(2) A licensed marijuana testing laboratory must, upon request of the Oregon Department of Agriculture, provide a test result and any other information or sample material to the Department.

(3) Notwithstanding the requirements of OAR 845-025-1230, a laboratory license may permit a registrant 18 years of age or older to be present on the licensed premises for the purpose of delivering a marijuana item for sampling and testing.

(4) Nothing in these rules prohibits a laboratory licensee from testing industrial hemp or industrial hemp commodities and products in accordance with Oregon Laws 2016, chapter 71, section 9.

Stat. Auth.: ORS 475B.560

Stats. Implemented: ORS 475B.560

Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-5300

Application for Marijuana Research Certificate

(1) The Commission shall issue Marijuana Research Certificates to qualifying public and private researchers who present research proposals that demonstrate:

(a) The proposed research would benefit the state's cannabis industry, medical research or public health and safety; and

(b) The proposed operation and methodology complies with all applicable laws and administrative rules governing marijuana licensees and licensee representatives.

(2) The process for applying for, receiving and renewing a certificate shall be the same as the process for applying for, receiving and renewing a marijuana license under OAR 845-025-1030 to 845-025-1115 except that an applicant for a Marijuana Research Certificate is not subject to the residency requirements in 845-025-1045(2)(b).

(3) In addition to the application requirements in OAR-025-1030 the applicant must also provide:

(a) A clear description of the research proposal;

(b) A description of the researchers' expertise in the scientific substance and methods of the proposed research;

(c) An explanation of the scientific merit of the research plan, including a clear statement of the overall benefit of the applicant's proposed research to Oregon's cannabis industry, medical research, or to public health and safety;

(d) Descriptions of key personnel, including clinicians, scientists, or epidemiologists and support personnel who would be involved in the research, demonstrating they are adequately trained to conduct this research;

(e) A clear statement of the applicant's access to funding and the estimated cost of the proposed research;

(f) A disclosure of any specific conflicts of interest that the researcher or other key personnel have regarding the research proposal;

(g) A description of the research methods demonstrating an unbiased approach to the proposed research;

(h) A description of the quantities of marijuana items, if any, that are proposed be transferred to licensees; and

(i) If the applicant intends to research the use of pesticides, an experimental use permit issued by Oregon Department of Agriculture pursuant to OAR 603-057-0160.

(4) Research certificates will be granted for up to a three-year term.

(5) The Commission may request that the research certificate holder submit information and fingerprints required for a criminal background check at any time within the research certificate term.

(6) A certificate holder may, in writing, request that the Commission waive one or more of these rules. The request must include the following information:

(a) The specific rule and subsection of a rule that is requested to be waived;

(b) The reason for the waiver;

(c) A description of an alternative safeguard the licensee can put in place in lieu of the requirement that is the subject of the waiver, or why such a safeguard is not necessary; and

(d) An explanation of how and why the alternative safeguard or waiver of the rule protects public health and safety, prevents diversion of marijuana, and provides for accountability.

(7) The Commission may, in its discretion, and on a case-by-case basis, grant the waiver in whole or in part if it finds:

(a) The reason the certificate holder is requesting the waiver is because another state or local law prohibits compliance; or

(b) The certificate holder cannot comply with the particular rule, for reasons beyond the certificate holder's control or compliance with the rule is cost prohibitive; or

(c) Because of the nature of the research, the Commissions finds that compliance with a particular rule is not necessary and that even with the waiver public health and safety can be protected, there is no increased opportunity for diversion of marijuana, and the certificate holder remains accountable.

(8) The Commission must notify the certificate holder in writing whether the request has been approved. If the request is approved the notice must specifically describe any alternate safeguards that are required and, if the waiver is time limited, must state the time period the waiver is in effect.

(9) The Commission may withdraw approval of the waiver at any time upon a finding that the previously approved waiver is not protecting public health and safety or the research certificate holder has other issues with compliance. If the Commission withdraws its approval of the waiver

the certificate holder will be given a reasonable period of time to come into compliance with the requirement that was waived.

Stat. Auth.: ORS 475B.235
Stats. Implemented: ORS 475B.235 & 2016 OL Ch. 24, Sec. 12 & 65
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-5350
Marijuana Research Certificate Privileges and Prohibitions

(1) A certificate holder may receive marijuana items from a licensee or a registrant under ORS 475B.400 to 475B.525.

(2) A certificate holder:

(a) May not:

(A) Sell or otherwise transfer marijuana items to any other person except when disposing of waste pursuant to OAR 845-025-7750, transferring to another certificate holder or transferring to another licensee.

(B) Transfer more to another licensee than is permitted in the Commission's order granting the research certificate.

(b) Must comply with the testing rules in OAR 333-007-0300 to 333-007-0490 applicable to a producer or processor prior to transferring marijuana items to a licensee.

(3) A certificate holder may not conduct any human subject research related to marijuana unless the certificate holder has received approval from an institutional review board that has adopted the Common Rule, 45 CFR Part 46.

(4) All administrative rules adopted by Commission for the purpose of administering and enforcing ORS Chapter; and any rules adopted thereunder with respect to licensees and licensee representatives apply to certificate holders except for those which are inconsistent with this rule.

Stat. Auth.: ORS 475B.235
Stats. Implemented ORS 475B.235 & 2016 OL Ch. 24, Sec. 12 & 65
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-5500
Marijuana Worker Permit and Retailer Requirements

(1) A marijuana worker permit is required for any individual who performs work for or on behalf of a marijuana retailer, producer, processor or wholesaler if the individual participates in:

(a) The possession, securing or selling of marijuana items at the premises for which the license has been issued;

(b) The recording of the possession, securing or selling of marijuana items at the premises for which the license has been issued;

(c) The verification of any document described in ORS 475B.170; or

(d) The direct supervision of a person described in subsections (a) to (c) of this section.

(2) An individual who is required by section (1) of this rule to hold a marijuana worker permit must carry that permit on his or her person at all times when performing work on behalf of a marijuana retailer.

(3) A person who holds a marijuana worker permit must notify the Commission in writing within 10 days of any conviction for a misdemeanor or felony.

(4) A marijuana retailer must verify that an individual has a valid marijuana worker permit issued in accordance with OAR 845-025-5500 to 845-025-5590 before allowing the individual to perform any work at the licensed premises.

Stat. Auth.: ORS 475B.215 & 475B.218
Stats. Implemented: ORS 475B.215, 475B.218 & 2016 OL Ch. 23, Sec. 16 & 17
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

845-025-5540
Marijuana Worker Permit Denial Criteria

(1) The Commission must deny an initial or renewal application if the applicant:

(a) Is not 21 years of age or older;

(b) Has had a marijuana license or worker permit revoked for violation of ORS 475B.010 to 475B.395 or any rule adopted under ORS 475B.010 to 475B.395 within two years of the date of the application;

(2) The Commission may deny an initial or renewal application, unless the applicant shows good cause to overcome the denial criteria, if the applicant:

(a) Has been convicted of a felony for possession, manufacture or delivery of a controlled substance within three years of the date the Commission received the application, except for convictions for the manufacture or delivery of marijuana if the date of the conviction is two or more years prior to the date of the application or renewal;

(b) Has been convicted of a felony for a crime involving violence within three years of the date the Commission received the application;

(c) Has been convicted of a felony for a crime of dishonesty or deception, including but not limited to theft, fraud, or forgery, within three years of the date the Commission received the application.

(d) Has been convicted of an offense under ORS 475.856, 475.858, 475.860 or 475.862 within three years of the date the Commission received the application.

(e) Has more than one conviction for any of the crimes listed in subsections (2)(a) to (d) of this rule within five years of the date the Commission received the application.

(f) Has violated any provision of ORS 475B.010 to 475B.395 or any rule adopted under ORS 475B.010 to 475B.395;

(g) Makes a false statement to the Commission.

(3) If the Commission denies an application under subsection (2)(f) to (g) of this rule the individual will not be eligible for a permit for two years from the date the Commission received the application.

(4) A Notice of Denial must be issued by the Commission in accordance with ORS Chapter 183.

Stat. Auth.: ORS 475B.215 & 475B.218
Stats. Implemented: ORS 475B.215, 475B.218 & 2016 OL Ch. 24, Sec. 13
Hist.: OLCC 3-2015(Temp), f. 12-3-15, cert. ef. 1-1-16 thru 6-28-16; OLCC 6-2016, f. 6-28-16, cert. ef. 6-29-16; OLCC 9-2016(Temp), f. 6-28-16, cert. ef. 6-30-16 thru 12-26-16

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Oregon Medical Board
Chapter 847

Rule Caption: Prescribers of Controlled Substances
Adm. Order No.: OMB 8-2016
Filed with Sec. of State: 7-8-2016
Certified to be Effective: 7-8-16
Notice Publication Date: 5-1-2016
Rules Amended: 847-015-0005, 847-015-0010, 847-015-0030
Subject: The rule amendment replaces "physician" with "licensee" or "health care professional" to reflect that the rules apply to all Oregon Medical Board licensees who are authorized to prescribe controlled substances. Therefore, the rules apply to physicians (medical, osteopathic, and podiatric physicians) and physician assistants.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-015-0005
Scheduled II Controlled Substance — Bariatrics Practice

(1) A licensee shall not utilize a Schedule II controlled substance for purposes of weight reduction or control.

(2) A violation of any provision of this rule, as determined by the Board, shall constitute Unprofessional Conduct as the term is used in ORS 677.188(4)(a), (b), or (c), whether or not actual injury to a patient is established.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.188 & 677.190
Hist.: ME 1-1987, f. & ef. 1-20-87; ME 1-1995, f. & cert. ef. 2-1-95; OMB 8-2016, f. & cert. ef. 7-8-16

847-015-0010
Schedule III or IV Controlled Substances — Bariatrics Practice

(1) A licensee shall not utilize a Schedule III or IV controlled substance for purposes of weight reduction, other than in accordance with federal Food and Drug Administration (FDA) product guidelines in effect at the time of utilization and with all the provisions of this rule.

(2) A licensee may utilize a Schedule III or IV controlled substance for purposes of weight reduction in the treatment of Exogenous Obesity in a regimen of weight reduction based on caloric restriction, behavior modification and prescribed exercise, provided that all of the following conditions are met:

(a) Before initiating treatment utilizing a Schedule III or IV controlled substance, the licensee thoroughly reviews the licensee's own records of prior treatment, or thoroughly reviews the records of prior treatment which another treating health care professional or weight-loss program has provided to the licensee, that one of the following conditions exist:

(A) Patient's body mass index exceeds 30 Kg/M sq; or

(B) Patient's body mass index exceeds 27 Kg/M sq and the excess weight represents a threat to the patient's health (as with hypertension, diabetes, or hypercholesterolemia.)

(b) Before initiating treatment utilizing a Schedule III or IV controlled substance, the licensee obtains a thorough history, performs a thorough physical examination of the patient, and rules out the existence of any rec-

ognized contraindications to the use of the controlled substance to be utilized.

(3) Continuation of Schedule III or IV designated as FDA short term use controlled substances beyond three (3) months requires documentation of an average two (2) pound per month weight loss during active weight reduction treatment, or documentation of maintenance of goal weight. Use of Schedule III or IV controlled substances with FDA approval for bariatric therapy and designated for long term use where FDA guidelines are followed may also be used beyond three months.

(4) A violation of any provision of this rule, as determined by the Board, shall constitute Unprofessional Conduct as the term is used in ORS 677.188(4)(a), (b), or (c), whether or not actual injury to a patient is established.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.188(4) & 677.190(24)
Hist.: ME 1-1987, f. & ef. 1-20-87; ME 1-1995, f. & cert. ef. 2-1-95; ME 1-1997, f. & cert. ef. 1-28-97; BME 9-1998, f. & cert. ef. 7-22-98; BME 17-2000(Temp), f. & cert. ef. 10-30-00 thru 2-28-01; BME 4-2001, f. & cert. ef. 1-25-01; OMB 8-2016, f. & cert. ef. 7-8-16

847-015-0030
Written Notice Disclosing the Material Risks Associated with Prescribed or Administered Controlled Substances for the Treatment of "Intractable Pain"

(1) Definitions

(a) "Controlled substance" has the meaning given that term under ORS 475.005.

(b) "Intractable pain" means a chronic pain state in which the cause of the pain cannot be removed or otherwise treated and for which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain has been found after reasonable efforts, including, but not limited to, evaluation by the treating health care professional.

(2) Controlled substances may be prescribed for long term treatment of intractable pain. The records must contain the health care professional's examination, diagnosis and any other supporting diagnostic evaluations and other therapeutic trials, including records from previous health care professionals. If there is a consulting health care professional, written documentation of his/her corroborating findings, diagnosis and recommendations shall be included in the record.

(3) Before initiating treatment of intractable pain with controlled substances or, when it is apparent that pain which is already being treated with controlled substances has now become intractable, the health care professional shall discuss with the patient the procedures, alternatives and risks associated with the prescribing or administering controlled substances for long term management of pain. Following the discussion, the patient will be given an opportunity to request further explanations. When the patient is satisfied with the explanation of the issues related to the prescribing of these drugs over long periods of time, the health care professional shall provide to the person and the person shall sign a written document outlining the issues discussed associated with the prescribed or administered controlled substances.

(4) The material risk notice should include but not be limited to:

(a) The diagnosis;

(b) The controlled substance and/or group of controlled substances to be used;

(c) Anticipated therapeutic results;

(A) Pain relief;

(B) Functional goals;

(d) Alternatives to controlled substance therapy;

(e) Potential additional therapies to be used in conjunction with controlled substances; and

(f) Potential side effects (if applicable):

(A) Cardiovascular;

(B) Central Nervous System;

(C) Gastrointestinal;

(D) Endocrine;

(E) Respiratory;

(F) Dermatologic;

(G) Urinary;

(H) Pregnancy, and

(I) Other.

(g) Allergy Potential;

(h) Interaction/Potentiation of other medications;

(i) Potential for dose escalation/tolerance;

(j) Withdrawal precautions;

(k) Potential for dependence and addiction;

(l) Potential for impairment of judgment and/or motor skills;

(m) Satisfaction with or desire for more explanation; and

(n) Patient signature (dated).

(5) The material risk consent form will be maintained as a permanent component of the patient record as shall documentation of long term follow-up to demonstrate the continued need for this form of therapy. A dispensing record of the amount and dose of the prescribed or administered controlled substances shall be maintained as part of the patient record.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.097, 677.190, 677.470, 677.474, 677.480
Hist.: ME 4-1996, f. & cert. ef. 7-26-96; BME 8-2000, f. & cert. ef. 7-27-00; BME 6-2004, f. & cert. ef. 4-22-04; BME 9-2008, f. & cert. ef. 4-24-08; OMB 8-2016, f. & cert. ef. 7-8-16

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Rule Caption: Supervising Physician Organizations
Adm. Order No.: OMB 9-2016
Filed with Sec. of State: 7-8-2016
Certified to be Effective: 9-1-16
Notice Publication Date: 5-1-2016
Rules Adopted: 847-050-0036
Rules Amended: 847-050-0010, 847-050-0027, 847-050-0037, 847-050-0040
Subject: The new OAR 847-050-0036 is a collective rule for all requirements for establishing and maintaining a supervising physician organization. The rule amendments (1) remove substantive provisions regarding agents, supervising physician organizations and supervision from the definitions rule; (2) add a definition for primary supervising physician; (3) clarify that a supervising physician must be able to be available for synchronous communication with the physician assistant; (4) require each supervising physician who is a member of a supervising physician organization to be approved by the Board as a supervising physician; (5) remove the requirement for the primary supervising physician of a supervising physician organization to attest that all member supervising physicians have reviewed the statutes and rules on PAs because all member physicians will have done this through the supervising physician application process; (6) require the Board to reduce the supervising physician application fee for physicians who volunteer in free or non-profit clinics; (7) clarify that the rules on supervision apply equally to supervising physician organizations, not just individual supervising physician-physician assistant teams; (8) require practice settings rather than locations to be listed in the practice agreement; (9) allow the supervising physicians within a supervising physician organization to collectively provide the 8 hours of on-site supervision and chart review; (10) outline statutory requirements for appropriate delegation of medical services to a physician assistant; and (11) provide the statutory language that requires the supervising physician or supervising physician organization to ensure competent practice of the physician assistant. The rule amendments also contain general grammar and housekeeping updates.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-050-0010
Definitions

As used in OAR 847-050-0005 to 847-050-0065:

(1) "Agent" means a physician designated in writing by the supervising physician who provides direction and regular review of the medical services of the physician assistant when the supervising physician is unavailable for short periods of time, such as but not limited to when the supervising physician is on vacation.

(2) "Board" means the Oregon Medical Board for the State of Oregon.

(3) "Grandfathered physician assistant" means the physician assistant registered prior to July 12, 1984, who does not possess the qualifications of OAR 847-050-0020. Grandfathered physician assistants may retain all practice privileges which have been granted prior to July 12, 1984.

(4) "Physician assistant" means a person who is licensed as such in accordance with ORS 677.265 and 677.495 through 677.535.

(5) "Practice agreement" means a written agreement between a physician assistant and a supervising physician or supervising physician organization that describes the manner in which the services of the physician assistant will be used.

(6) "Practice description" means a written description of the duties and functions of the physician assistant in relation to the physician's prac-

tice, submitted by the supervising physician and the physician assistant to the Board and approved prior to January 1, 2012.

(7) "Primary supervising physician" means a supervising physician within a supervising physician organization who is designated to provide the administrative direction for the supervising physician organization.

(8) "Supervising physician organization" means a group of supervising physicians who collectively supervises a physician assistant.

(9) "Supervising physician" means a physician licensed under ORS Chapter 677, actively registered and in good standing with the Board as a Medical Doctor or Doctor of Osteopathic Medicine, and approved by the Board as a supervising physician, who provides direction and regular review of the medical services provided by the physician assistant.

(10) "Supervision" means the routine review by the supervising physician or designated agent, as described in the practice agreement or Board-approved practice description of the medical services provided by the physician assistant. There are three categories of supervision:

(a) "General Supervision" means the supervising physician or designated agent is not on-site with the physician assistant, but must be available for direct communication, either in person, by telephone, or other synchronous electronic means.

(b) "Direct Supervision" means the supervising physician or designated agent must be in the facility when the physician assistant is practicing.

(c) "Personal Supervision" means the supervising physician or designated agent must be at the side of the physician assistant at all times, personally directing the action of the physician assistant.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.495
Hist.: ME 23(Temp), f. & ef. 10-12-71; ME 25, f. 1-20-72, ef. 2-1-72; ME 1-1979, f. & ef. 1-29-79; 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 2-1990, f. & cert. ef. 1-29-90; ME 10-1992, f. & cert. ef. 7-17-92; BME 4-2002, f. & cert. ef. 4-23-02; BME 13-2003, f. & cert. ef. 7-15-03; BME 12-2006, f. & cert. ef. 5-8-06; BME 19-2010, f. & cert. ef. 10-25-10; [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 9-2016, f. 7-8-16, cert. ef. 9-1-16

847-050-0027
Approval of Supervising Physician

(1) Prior to using the services of a physician assistant under a practice agreement, a supervising physician, including the primary supervising physician and each supervising physician within a supervising physician organization, must be approved as a supervising physician by the Board.

(2) Physicians applying to be a supervising physician 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.

(3) The Board will reduce the supervising physician application fee for physicians volunteering in free clinics or non-profit organizations.

(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; or

(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; OMB 37-2013, f. & cert. ef. 10-15-13; OMB 9-2016, f. 7-8-16, cert. ef. 9-1-16

847-050-0036
Supervising Physician Organization

(1) A supervising physician organization must designate one physician within the supervising physician organization to also serve as the primary supervising physician of the supervising physician organization.

(2) Each supervising physician in a supervising physician organization, including the primary supervising physician, must be approved by the Board as a supervising physician.

(3) The supervising physician organization must provide the Board with a letter containing:

(a) The name of the supervising physician organization;

(b) The address and phone number for the supervising physician organization;

(c) The name of the primary supervising physician; and

(d) The names of the supervising physicians in the supervising physician organization.

(4) The supervising physician organization must notify the Board in writing within 10 days of any change in the name, address, phone number, or supervising physicians in the supervising physician organization.

(5) A supervising physician organization may include any number of supervising physicians.

(6) A supervising physician organization may supervise any number of physician assistants.

(7) A physician assistant who is supervised by a supervising physician organization may be supervised by any of the supervising physicians in the supervising physician organization.

(8) The Board may request a meeting with a supervising physician organization and a physician assistant to discuss a practice agreement.

Stat. Auth.: ORS 677.265, 677.510
Stats. Implemented: ORS 677.495, 677.510, 677.515
Hist.: OMB 9-2016, f. 7-8-16, cert. ef. 9-1-16

847-050-0037
Supervision

(1) A physician may not use the services of a physician assistant without first obtaining Board approval as a supervising physician.

(2) The supervising physician, agent, or in the case of a supervising physician organization, the primary supervising physician and the supervising physician who is providing supervision for the physician assistant, are personally responsible for the direction, supervision and regular review of the medical services provided by the physician assistant, in keeping with the practice agreement or Board-approved practice description.

(3) The type of supervision and maintenance of supervision provided for each physician assistant must be described in the practice agreement or Board-approved practice description.

(4) The supervising physician, agent or, in the case of a supervising physician organization, the supervising physician who is providing supervision for the physician assistant must be available for direct communication with the physician assistant at all times in person, by telephone, or through other synchronous electronic means, whether the supervising physician and physician assistant practice in the same practice location or a practice location separate from each other.

(5)(a) Each setting and licensed facility in which the physician assistant will provide services must be listed in the practice agreement or Board-approved practice description.

(b) Additional, intermittent practice settings such as schools, sporting events, health fairs and long term care facilities, are not required to be listed in the practice agreement or Board-approved practice description if the duties are the same as those listed in the practice agreement or Board-approved practice description. The medical records for the patients seen at these additional practice settings must be held either at the supervising physician's primary practice setting or the additional practice settings. The supervision of the physician assistant must be the same as that described in the practice agreement or Board-approved practice description.

(6) The supervising physician, agent or the supervising physicians in the supervising physician organization must:

(a) Provide a minimum of eight (8) hours of on-site supervision every month, or as approved by the Board; and

(b) Provide chart review of a number or a percentage of the patients the physician assistant has seen as stated in the practice agreement or Board-approved practice description.

(7) The supervising physician may limit the degree of independent judgment that the physician assistant uses but may not extend it beyond the limits of the practice agreement or Board-approved practice description.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.495, 677.510, 677.515
Hist.: ME 4-1981(Temp), f. & ef. 10-20-81; ME 2-1982; f. & ef. 1-28-82; ME 8-1985, f. & ef. 8-5-85; ME 2-1990, f. & cert. ef. 1-29-90; BME 1-1998, f. & cert. ef. 1-30-98; BME 9-1999, f. & cert. ef. 4-22-99; BME 2-2000, f. & cert. ef. 2-7-00; BME 4-2002, f. & cert. ef. 4-23-02; BME 4-2005, f. & cert. ef. 4-21-05; BME 20-2008, f. & cert. ef. 7-21-08; BME 12-2009(Temp), f. & cert. ef. 7-14-09 thru 12-14-09; BME 19-2009, f. & cert. ef. 10-23-09; [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 9-2016, f. 7-8-16, cert. ef. 9-1-16

847-050-0040
Method of Performance

(1) The physician assistant may perform at the direction of the supervising physician, agent or, in the case of a supervising physician organization, the primary supervising physician or the supervising physician who is providing supervision for the physician assistant only those medical services as included in the practice agreement or Board-approved practice description.

(2) A medical service may be delegated to and performed by a physician assistant if:

(a) The services are provided under the appropriate supervision of a supervising physician;

(b) The services are within the scope of practice and the competency of the supervising physician;

(c) The services are within the scope of practice and the competency of the physician assistant;

(d) The services are generally described in and in compliance with the practice agreement or Board-approved practice description; and

(e) The physician assistant has obtained informed consent as provided in ORS 677.097, if informed consent is required.

(3) The supervising physician shall ensure that the physician assistant is competent to perform all duties delegated to the physician assistant. The supervising physician or supervising physician organization and the physician assistant are responsible for ensuring the competent practice of the physician assistant.

(4) The physician assistant or student must be clearly identified as such when performing duties. The physician assistant must at all times when on duty wear a name tag with the designation of "physician assistant" or "PA" thereon and clearly identify himself or herself as a "physician assistant" or "PA" in oral communications with patients and other professionals.

(5) The supervising physician must furnish reports, as required by the Board, on the performance of the physician assistant or student.

(6) The practice agreement must be submitted to the Board within ten days after the physician assistant begins practice with the supervising physician or supervising physician organization.

(7) The supervising physician must notify the Board of any changes to the practice agreement within ten days of the effective date of the change.

(8) Supervising physicians must update the practice agreement biennially during the supervising physician's license renewal process.

(9) A supervising physician and physician assistant who have a Board-approved practice description that was approved prior to January 1, 2012 and who wish to make changes to the practice description must enter into a practice agreement in accordance with ORS 677.510(6)(a).

(10) Failure to comply with any section of this rule is a violation of ORS 677.510 and is grounds for a $195 fine imposed on the non-compliant licensee. The licensee may be subject to further disciplinary action by the Board.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.205, 677.510, 677.515
Hist.: ME 23(Temp), f. & ef. 10-12-71; ME 25, f. 1-20-72, ef. 2-1-72; ME 1-1979, f. & ef. 1-29-79; 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 8-1985, f. & ef. 8-5-85; ME 5-1986, f. & ef. 4-23-86; ME 2-1990, f. & cert. ef. 1-29-90; ME 10-1992, f. & cert. ef. 7-17-92; [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 31-2012, f. & cert. ef. 10-22-12; OMB 9-2016, f. 7-8-16, cert. ef. 9-1-16

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Oregon Racing Commission
Chapter 462

Rule Caption: Prohibits using Clenbuterol in horses competing in Quarter Horse races at all tracks in Oregon.

Adm. Order No.: RC 4-2016
Filed with Sec. of State: 6-17-2016
Certified to be Effective: 6-17-16
Notice Publication Date: 5-1-2016
Rules Amended: 462-160-0130
Subject: Amends current rule to prohibit the use of Clenbuterol in American Quarter Horses at all race tracks in Oregon. Also prohibits the use of Clenbuterol in any breed of horse racing in a Quarter Horse race.
Rules Coordinator: Karen Parkman—(971) 673-0208

462-160-0130
Medications and Prohibited Substances

(1) No horse may be administered any substance, other than foods, by any route or method less than 24 hours before the original post time for the race in which the horse is entered except furosemide (by the manner described in these rules) unless approved by a commission veterinarian:

(a) Any licensee of the commission, including veterinarians, found to be responsible for the improper or intentional administration of any drug resulting in a positive test may, after proper notice and hearing, be subject to the same penalties set forth for the licensed trainer;

(b) The licensed trainer is responsible for notifying the licensed owner, veterinarian or any other licensed party involved in a positive laboratory finding of any hearings and any resulting action. In addition their presence may be required at any and all hearings relative to the case;

(c) Any veterinarian found to be involved in the administration of any drug with an RCI Classification of 1, 2, or 3, involved in a prohibited practice as outlined in OAR 462-160-0120, or involved in an ORS 462 violation shall be referred to the State Licensing Board of Veterinary Medicine for consideration of further disciplinary action and/or license revocation. This is in addition to any penalties issued by the stewards or the commission;

(d) Any person who the stewards or the commission believe may have committed acts in violation of criminal statutes may be referred to the appropriate law enforcement agency. Administrative action taken by the stewards or the commission does not prohibit a prosecution for criminal acts committed, nor does a potential criminal prosecution stall administrative action by the stewards or the commission;

(e) A licensed trainer shall not benefit financially during the period for which the individual has been suspended. This includes, but is not limited to, ensuring that horses are not transferred to licensed family members.

(2) Medication Restrictions:

(a) A finding by the commission approved laboratory of a prohibited drug, chemical or other substance in a test specimen of a horse is prima facie evidence that the prohibited drug, chemical or other substance was administered to the horse and, in the case of a race day test, was present in the horse's body on race day. Prohibited substances include:

(A) Drugs or medications for which no acceptable threshold concentration has been established;

(B) Therapeutic medications in excess of established threshold concentrations;

(C) Substances present in the horse in excess of concentrations at which such substances could occur naturally; and

(D) Substances foreign to a horse at concentrations that cause interference with testing procedures.

(b) Except as otherwise provided by this chapter, a person may not administer or cause to be administered by any means to a horse a prohibited drug, medication, chemical or other substance, including any restricted medication pursuant to this chapter less than 24-hours before post time for the race in which the horse is entered.

(3) Medical Labeling:

(a) No person on association grounds where horses are lodged or kept, excluding licensed veterinarians, shall have in or upon association grounds which that person occupies or has the right to occupy, or in that person's personal property or effects or vehicle in that person's care, custody or control, a drug, medication, chemical, foreign substance or other substance that is prohibited in a horse on a race day unless the product is labeled in accordance with this subsection;

(b) Any drug or medication which is used or kept on association grounds and which, by federal or state law, requires a prescription must have been validly prescribed by a duly licensed veterinarian, and in compliance with the applicable state statutes. All such allowable medications must have a prescription label which is securely attached and clearly ascribed to show the following:

(A) The name of the product;

(B) The name, address and telephone number of the veterinarian prescribing or dispensing the product;

(C) The name of each patient (horse) for whom the product is intended/prescribed;

(D) The dose, dosage, duration of treatment and expiration date of the prescribed/dispensed product; and

(E) The name of the person (trainer) to whom the product was dispensed.

(4) Non-Steroidal Anti-Inflammatory Drugs (NSAIDs):

(a) The use of one of three approved NSAIDs shall be permitted under the following conditions:

(A) The approved NSAIDs shall be authorized medication at race meets at which the average daily gross mutuel wagering during the preceding year exceeded $150,000. If a race meet with average daily gross mutuel wagering during the preceding year of $150,000 or less desires NSAIDs be authorized medications at their race meet they may petition the commission to approve the use of permitted NSAIDs at their race meet. The commission may approve the use of permitted NSAIDs at such race meet, if in the opinion of the commission the race meet can provide for the necessary qualified staffing, security and for the additional laboratory analysis costs and any other controls necessary to administer the program adequately. Horses on any permitted NSAID will be designated on the overnight and the daily racing program;

(B) No horse utilizing a permitted NSAID may be entered into a race unless the presence of the specific NSAID is stated on the entry form at the time of entry. Errors may be corrected up until scratch time. If no scratch time is used, the stewards may designate a time until which errors may be corrected;

(C) Not to exceed the following permitted serum or plasma threshold concentrations which are consistent with administration by a single intravenous injection not less than 24-hours before the post time for the race in which the horse is entered:

(i) Phenylbutazone (or its metabolite oxyphenylbutazone) — 5 micrograms per milliliter;

(ii) Flunixin — 50 nanograms per milliliter;

(iii) Ketoprofen — 10 nanograms per milliliter.

(D) These or any other NSAID are prohibited to be administered within the 24-hours before the original post time for the race in which the horse is entered;

(E) The presence of more than one of the three approved NSAIDs in serum or plasma is not permitted in a race day sample; however, the presence of two approved NSAIDs in a race day sample is allowed if one of them is phenylbutazone with a serum or plasma concentration less than one microgram per milliliter (mcg/ml).

(F) The presence of any unapproved NSAID in serum, plasma or urine sample is not permitted in a race day sample.

(b) Any horse to which an NSAID has been administered shall be subject to having a blood and/or urine sample(s) taken at the direction of a commission veterinarian to determine the quantitative NSAID level(s) and/or the presence of other drugs which may be present in the blood or urine sample(s);

(c) When listed to race on a permitted NSAID, the approved laboratory must be able to detect the presence of a permitted NSAID in serum, plasma or urine by the routine methods of detection;

(d) If a permitted NSAID is detected in the urine or in any other specimen taken from a horse not stated to have permitted medication in its system on the entry form and/or program, the violation will result in a penalty to the horse's trainer and may result in loss of purse;

(e) If the same horse has three (3) overages of any permitted NSAID during a 365 day period a commission veterinarian may rule the horse off all NSAIDs for a period of one year (365 days);

(f) The decision of whether to scratch a horse which has been entered incorrectly or is incorrectly treated shall be left to the discretion of a commission veterinarian.

(5) Furosemide:

(a) The commission may approve the use of furosemide at any race meet if, in the opinion of the commission, the race meet can provide the necessary qualified staffing, security and for the additional laboratory analysis costs and any other controls necessary to administer a furosemide program;

(b) Furosemide may be administered intravenously to a horse, which is entered to compete in a race. Except under the instructions of a commission veterinarian or the racing veterinarian for the purpose of removing a horse from the Veterinarian's List or to facilitate the collection of a post-race urine sample, furosemide shall be permitted only if the following process is followed:

(A) After the horse's licensed trainer and licensed veterinarian determine that it would be in the horse's best interests to race with furosemide, the horse may be so entered.

(B) The horse may discontinue from racing on furosemide at the licensed trainer's choice at the time of entry.

(C) Furosemide shall only be administered on association grounds;

(D) Upon the request of the regulatory agency designee, the veterinarian administering the authorized bleeder medication shall surrender the syringe used to administer such medication which may then be submitted for testing.

(c) Horses to run with furosemide must be so noted on the entry form at the time of entry. Errors may be corrected up until scratch time. If no scratch time is used, the stewards may designate a time until which errors may be corrected:

(A) Horses entered to race with furosemide will be designated on the overnight and the daily racing program with a "Lasix®" or "L". If the race is the first race the horse is to run in on furosemide, it shall be designated in the daily racing program with a "1-L". If the race is the first race the horse runs without furosemide after running one or more races with furosemide, it shall be designated in the program by "O-L" or "L-X";

(B) When discovered prior to the race, errors in the listing of furosemide treatments in the program shall be announced to the public.

(d) The use of furosemide shall be permitted under the following circumstances:

(A) Furosemide shall be administered no more than five hours but not less than four hours prior to the original scheduled post time for the race for which the horse is entered;

(B) The furosemide dosage administered shall not exceed 500 mg. nor be less than 150 mg;

(C) Furosemide shall be administered by a single, intravenous injection;

(D) The veterinarian treating the horse shall cause to be delivered to a commission veterinarian or designated representative no later than one hour prior to post time for the race for which the horse is entered the following information under oath on a form approved by a commission veterinarian:

(i) The name of the horse, racetrack name, the date and time the furosemide was administered to the entered horse;

(ii) The dosage amount of furosemide administered to the entered horse; and

(iii) The printed name and signature of the attending licensed veterinarian who administered the furosemide;

(iv) Violations of this subsection (subsection (d)) shall result in a fine and scratch from the race the horse was entered to run. Violations may also result in a commission veterinarian ordering the loss of furosemide privileges.

(e) Test results must show a detectable concentration of the drug in the race day serum, plasma or urine sample. If furosemide is not detected in a race day sample, a penalty may be imposed upon the horse's trainer without loss of purse:

(A) Quantification of furosemide in serum or plasma shall be performed. Concentrations of furosemide in serum or plasma shall not exceed 100 nanograms of furosemide per milliliter of serum or plasma. When the concentration of furosemide exceeds 100 nanograms of furosemide per milliliter of serum or plasma, specific gravity of the corresponding urine sample shall be measured.

(B) The specific gravity of race day urine samples may be measured to ensure that samples are sufficiently concentrated for proper chemical analysis. The specific gravity shall not be below 1.010.

(f) Unauthorized use of furosemide shall result in a penalty to the horse's trainer;

(g) The decision of whether to scratch a horse which has been entered incorrectly or is incorrectly treated shall be left to the discretion of a commission veterinarian;

(h) A commission veterinarian may rule a horse off furosemide if in his/her opinion it is in the horse's best interest, the interest of the citizens of the state or the best interest of horse racing.

(6) Bleeder List:

(a) The commission veterinarians shall maintain a Bleeder List of all horses, which have demonstrated external evidence of exercise induced pulmonary hemorrhage from one or both nostrils during or after a race or workout as observed by a commission veterinarian;

(b) Every confirmed bleeder, regardless of age, shall be placed on the Bleeder List and be ineligible to enter for the following time periods:

(A) First incident — 14 days;

(B) Second incident within 365 day period — 30 days;

(C) Third incident within 365 day period — 180 days;

(D) Fourth incident within 365-day period — barred for racing lifetime.

(c) For the purposes of counting the number of days a horse is ineligible to be entered for a race, the day the horse bled externally is the first day of the recovery period;

(d) The voluntary administration of furosemide without an external bleeding incident shall not subject the horse to the initial period of ineligibility as defined by this policy;

(e) A horse may be removed from the Bleeder List only upon the direction of a commission veterinarian;

(f) A horse which has been placed on a Bleeder List in another jurisdiction pursuant to these rules shall be placed on a Bleeder List in this jurisdiction.

(7) Anti-Ulcer Medications. The following anti-ulcer medications are permitted to be administered, at the stated dosage, up to 24 hours prior to the post time for a race in which the horse is entered:

(a) Cimetidine — 8-20 mg/kg by mouth two to three times a day; and

(b) Omeprazole — 2.2 grams by mouth once a day; and

(c) Ranitidine — 6.6 mg/kg by mouth three times a day.

(8) Environmental Contaminants and Substances of Human Use:

(a) The following substances can be environmental contaminants in that they are endogenous to the horse or that they can arise from plants traditionally grazed or harvested as equine feed or are present in equine feed because of contamination during the cultivation, processing, treatment, storage or transportation phases: Polyethylene glycol (PEG), PEG-like substances, Hordenine;

(b) Regulatory thresholds have been set for the following substances: Caffeine — 100 nanograms of caffeine per milliliter of serum or plasma;

(c) If the preponderance of evidence presented in the hearing shows that a positive test is the result of environmental contamination or inadvertent exposure due to human drug use it should be considered as a mitigating factor in any disciplinary action taken against the affected trainer.

(9) Dimethylsulfoxide (DMSO): The use of DMSO shall be permitted under the following conditions:

(a) It is only administered as an external topical application;

(b) A test sample shall not exceed 10 micrograms / ml. in serum of DMSO or its analogs.

(10) Androgenic-Anabolic Steroids (AAS)

(a) No AAS shall be permitted in test samples collected from racing horses except for residues of the major metabolite of stanozolol, nandrolone, and the naturally occurring substances boldenone and testosterone at concentrations equal to or less than the indicated thresholds.

(b) Concentrations of these AAS shall not exceed the following urine threshold concentrations in total (free drug; or metabolite and drug; or metabolite liberated from its conjugates):

(A) 16beta-hydroxystanozolol (metabolite of stanozolol (Winstrol)): 1 ng/ml for all horses regardless of sex.

(B) Boldenone (Equipoise® is the undecylenate ester of boldenone) in:

(i) Male horses other than geldings — 15 ng/ml.

(ii) No boldenone shall be permitted in geldings or female horses.

(C) Nandrolone (Durabolin® is the phenylpropionate ester and Deca-Durabolin® is the decanoate ester) in:

(i) Geldings — 1 ng/ml.

(ii) Fillies and mares — 1 ng/m.l

(iii) In male horses other than geldings — forty-five (45) ng/ml of nandrolone metabolite, 5a-oestrane-3ß17a-diol

(D) Testosterone in:

(i) Geldings — 20 ng/ml.

(ii) Fillies and mares — 55 ng/ml.

(iii) Male horses other than geldings — Testosterone will not be tested.

(c) All other AAS are prohibited in racing horses.

(d) Race day urine samples collected from intact males must be identified to the laboratory.

(e) Any horse to which an anabolic steroid has been administered in order to assist in the recovery from illness or injury may be placed on the veterinarian's list in order to monitor the concentration of the drug or metabolite in urine. After the urine concentration has fallen below the designated threshold for the administered AAS, the horse is eligible to be removed from the list.

(11) Clenbuterol:

(a) The use of Clenbuterol shall be permitted under the following conditions: A test sample shall not exceed 2 picograms/milliliter (ml) of Clenbuterol in the blood or serum.

(b) Notwithstanding (11)(a), the use of Clenbuterol, albuterol, zilpaterol, ractopamine or any analogues thereof in American Quarter Horse racing at recognized race tracks in Oregon is prohibited. All horses entering an official Quarter Horse race will be subject to testing by any biologic method including but not limited to hair, blood and urine.

Stat. Auth.: ORS 462.270(3)
Stats. Implemented: ORS 462.270 & 462.415
Hist.: RC 2-2006(Temp), f. & cert. ef. 10-2-06 thru 3-21-07; RC 1-2007, f. 2-28-07, cert. ef. 3-7-07; RC 6-2007(Temp), f. & cert. ef. 11-28-07 thru 5-23-08; RC 1-2008, f. & cert. ef. 4-7-08; RC 2-2008, f. & cert. ef. 9-30-08; RC 2-2009, f. 8-24-09, cert. ef. 10-1-09; RC 1-2010, f. 9-23-10, cert. ef. 10-1-10; RC 1-2012(Temp), f. 5-21-12, cert. ef. 5-22-12 thru 11-17-12; RC 4-2012, f. 11-14-12, cert. ef 11-15-12; RC 4-2016, f. & cert. ef. 6-17-16

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Oregon State Lottery
Chapter 177

Rule Caption: Clarifies division of top prize when won by multiple tickets in single drawing; housekeeping edits
Adm. Order No.: LOTT 4-2016(Temp)
Filed with Sec. of State: 7-14-2016
Certified to be Effective: 8-9-16 thru 1-31-17
Notice Publication Date:
Rules Amended: 177-094-0080
Subject: The Oregon Lottery has initiated temporary and permanent rulemaking to amend the above referenced administrative rule to clarify the process when the Win for Life top prize is won by multiple ticket holders in a single drawing and the prize cannot be divided evenly among the winners. Other edits are housekeeping changes to amend cross references.
Rules Coordinator: Mark W. Hohlt—(503) 540-1417

177-094-0080
Prizes

(1) General: Prizes for a winning ticket are determined by matching each horizontal set in the ticket's game play with the winning numbers from the relevant drawing. [Table not included. See ED. NOTE.]

(2) Prize Percentage Payout: The number of prizes for the Win for Life^{SM} game is not predetermined by the Lottery. The overall prize percentage payout for the Win for Life^{SM} game is estimated at approximately 65% over time, but the actual prize payout may vary from day-to-day and year-to-year due to factors that include, but are not limited to, the numbers of players participating each day and the number of winning wagers.

(3) Disputes: In the event of a dispute over the value of a prize or whether a ticket contains winning numbers or is a winning ticket, the Director's determination is controlling.

(4) Multiple Prizes:

(a) Subject to the validation requirements in OAR 177-094-0060, for each drawing, a player may receive multiple prizes on each ticket for which a ticket containing a winning game play is eligible.

(b) Only the top-prize associated with each set of numbers within the Win for Life^{SM}, $50,000, $20,000, and $10,000 prize categories shall be paid.

(5) Claiming a Prize: Prize payments must be claimed, and shall be made, in accordance with the provisions of OAR 177-070-0025. Notwithstanding OAR 177-070-0025(2) and subject to section (7) of this rule, a person who claims a Win for Life^{SM} top prize of $1,000 a week for life must present the winning ticket and completed claim form in person, at Lottery Headquarters in Salem, Oregon.

(6) Payment of Prizes: Upon validation of a winning ticket, a prize resulting from that winning ticket shall be paid to the prize winner in one lump-sum except for the Win for Life^{SM} prize of $1,000 per week for life.

(7) Win for Life^{SM} Top Prize:

(a) General: The Win for Life^{SM} top prize is $1000 per week for life. Only one natural person may own a winning ticket for the Win for Life^{SM} top prize of $1,000 per week for life, and claim the Win for Life^{SM} top prize of $1,000 per week for life. Notwithstanding OAR 177-046-0110(6), a winning ticket of the Win for Life^{SM} top prize cannot be owned jointly and the top prize will only be paid to the owner of the winning ticket.

(b) Ownership: Only one natural person may sign a Win for Life^{SM} top prize of $1000 per week for life winning ticket. A winning ticket of a

Win for Life^{SM} top prize is owned by the natural person who first signs the ticket and cannot be claimed by multiple owners. In the event a single winning ticket is signed by more than one natural person, the natural persons who signed the ticket must identify the natural person who first signed the ticket on a form provided by the Lottery.

(A) No Relinquishment: Notwithstanding OAR 177-046-0110(6)(c), ownership of a winning ticket of a Win for Life^{SM} top prize of $1000 per week for life cannot be relinquished.

(B) Deceased Signatory: If the owner of a winning ticket of a Win for Life^{SM} top prize dies before the prize is claimed, the personal representative of the owner's estate as appointed by a court, may claim the prize on behalf of the owner's estate. The maximum prize is $260,000 as set forth in subsection (f) and will be paid by the Lottery to the owner's estate in one lump sum.

(c) Payment Options: The Win for Life^{SM} top prize is $1,000 per week for life and shall be paid, based upon a selection made by the prize winner, either as:

(A) Weekly: A prize payment of $1000 each week beginning on the date prize payment is initiated upon validation of the winning ticket and thereafter on the same day each week, or if such day falls on a non-business day, then the next business day; or

(B) Annually: A payment of $52,000 paid annually beginning on the date prize payment is initiated upon validation of the winning ticket and thereafter on the anniversary date of the first payment, or if such date falls on a non-business day, then the first business day following the anniversary date of the first payment.

(d) Payments to Cease upon Winner's Death: The Win for Life^{SM} top prize of $1,000 per week for life will be paid to the prize winner until such time as the prize winner dies at which time all further prize payments shall cease.

(e) Five-Year Guaranteed Payment: Notwithstanding subsection (d) of this section, if the prize winner dies within five years of the date of prize validation, the Lottery shall pay any remaining prize payments the prize winner would have received within the first five years after prize validation in one lump sum to the individual designated on a beneficiary designation form or to the prize winner's estate.

(f) Maximum Five-Year Guaranteed Payment: Notwithstanding subsections (d) and (e) of this section, for Win for Life^{SM} tickets purchased on or after December 1, 2010, if the prize winner dies within five years of the date of prize validation, the Lottery shall pay any remaining prize payment the prize winner would have received within the first five years after prize validation in one lump sum, up to a maximum of $260,000, to the individual designated on a beneficiary designation form or to the prize winner's estate.

(g) Election of Payment Schedule:

(A) Limitations of Election: At the time of the validation of a winning Win for Life^{SM} ticket for the top prize of $1000 per week for life, the prize winner of the top prize must elect either the weekly or annual prize payment schedule described in subsection (b) of this section. A prize winner who elects the annual payment schedule cannot subsequently convert to the weekly payment schedule. The election of the annual payment schedule is irrevocable. A prize winner who elected the weekly payment schedule may convert to the annual payment schedule at any time, and the Lottery will issue payment to the prize winner for the sum of the remaining weekly payments from that date to the next anniversary date. Subsequent annual payments will be made on the anniversary date.

(B) Election When Child Support Owed: Notwithstanding subsection (A) of this subsection and subsection (g) of this section, when a search of delinquent child support obligors performed pursuant to ORS 461.715 and OAR 177-010-0090 Child Support Validation Check results in a positive match with the prize winner and the Division of Child Support of the Department of Justice (DOJ) or its successor initiates garnishment proceedings, the prize winner of the Win for Life^{SM} top prize of $1,000 per week for life has no payment options from which to select and will be placed on the annual payment schedule as described in subsection (7)(c)(B) of this section. This placement on the annual payment schedule is irrevocable.

(C) Conversion to Annual Payment Schedule upon Garnishment from Department of Justice: Upon receipt of garnishment proceedings from DOJ directed to the Lottery for monies due or to become due to a prize winner receiving weekly payments under the Win for Life^{SM} top prize of $1000 per week for life, the Lottery will place that prize winner on the annual payment schedule as described in subsection (7)(c)(B) of this section. Conversion of the prize winner's payment schedule from weekly to annual under this section of the rule is irrevocable. The Lottery shall make payments to such a prize winner as follows:

(i) Payment Less Garnishment Amounts: Within a reasonable time after the disposition of the garnishment proceeding, the Lottery shall pay the prize winner the sum of the prize winner's weekly payments from the date the Lottery placed the prize winner's payments on hold to the prize winner's next anniversary date less any amounts withheld pursuant to the garnishment proceedings and applicable tax laws.

(ii) Subsequent Payments: The Lottery shall make any subsequent annual payments, less any amounts withheld pursuant to the garnishment proceedings and applicable tax laws, on the anniversary date of the validation of the prize or on the next business day following if the anniversary date is a Saturday, Sunday, holiday or furlough closure day.

(h) Limitation on Prize Amount for Multiple Top Prize Winning Tickets: Where there are more than three winning tickets in a single Win for Life^{SM} drawing, the maximum combined annual top prize payout for a single Win for Life^{SM} drawing is $156,000.

(A) More Than Three Winning Tickets: Notwithstanding the $1,000 per week amount referred to in this rule, if there are more than three winning tickets for a Win for Life^{SM} top prize of $1,000 per week for life in a single drawing, the annual top prize payment per winning ticket shall be limited to $156,000 divided by the number of winning tickets of the Win for Life^{SM} top prize in that drawing.

(B) Example: For example, if there are four Win for Life^{SM} top prize winning tickets in a single drawing, the annual top prize amount is calculated by dividing 4 into $156,000 which equals $39,000 as the annual prize payment amount per each winning ticket.

(C) Payment: Notwithstanding subsection (g) of this section, the prize winner will be paid on an annual prize payment schedule. This placement on the annual prize payment schedule is irrevocable.

(D) Effect of Subsequent Events: Subsequent events, including, but not limited to, the death of one of the prize winners, shall not alter the other prize winners' original pro rata share of the calculated prize amount.

(E) Division of Prize: If there are multiple winners of the Win for Life^{SM} top prize in a single drawing such that the prize cannot be divided equally among the winners to a whole cent, the prize payments may be rounded down so that the prize may be divided equally and paid to the nearest whole cent to each winner. Breakage from rounding the prize shall be treated as an unclaimed prize by the Lottery.

(F) Example: If there are seven Win for Life^{SM} top prize winning tickets in a single drawing, the annual top prize amount paid to each winner is calculated by dividing 7 into $156,000 which equals $22,285.714285…. The Lottery shall round that amount down to $22,285.71 which totals $155,999.97 paid to the seven winners. The breakage of three cents shall then be treated as an unclaimed prize.

(i) Initiation of Payment: Prize payment is initiated upon validation of a winning ticket.

(j) Electronic Fund Transfer: After the initial prize payment issued to a Win for Life^{SM} top prize winner, the Lottery shall pay both weekly and annualized Win for Life^{SM} prize installments via electronic funds transfer in the usual course of Lottery business.

(k) Annual Affidavit Required:

(A) General: Once each year and no earlier than thirty days prior to the anniversary of the original validation date, a prize winner of a Win for Life^{SM} top prize of $1,000 per week for life shall provide the Lottery with an affidavit on a form provided by the Lottery, signed by the prize winner, bearing the seal of a notary public, verifying the prize winner is living, containing the prize winner's current address, and a bank account number to which the prize shall be paid.

(B) Termination of Prize: If a prize winner of a Win for Life^{SM} prize of $1,000 per week for life does not provide the Lottery with the affidavit described in subsection (i)(A) of this section, then the Lottery shall not make further prize payments to the prize winner. If the failure of a prize winner to provide the affidavit continues to the next anniversary of the validation date, the remainder of the prize shall be terminated.

(C) Exception: Notwithstanding paragraph (B) of this subsection, when it is reasonable and prudent to do so based on the facts underlying a prize winner's failure to provide an annual affidavit, the Director may authorize prize payment even though an affidavit has not been provided or is not timely provided. No interest shall be paid by the Lottery on the value of the prize during the period a prize remained unclaimed.

(l) Death During a Payment Year: If a prize winner of a Win for Life^{SM} top prize of $1,000 per week for life dies after five years have elapsed from the date of validation and if a sequence of weekly prize payments are paid over the course of the year in which the prize winner dies or

if a single annual prize payment has been paid prospectively to the winning player for that year, the prize could be overpaid. It is the policy of the Lottery that the difference between the prize that should have been paid based on the date of the death of the prize winner relative to the anniversary date of validation of the prize and the prize amount that was actually paid during the year in which the prize winner died will not be subject to reimbursement by the Lottery. Any prize payment paid after the year in which the prize winner dies relative to the anniversary date of validation of the prize shall be subject to reimbursement to the Lottery.

(m) Non-Assignability: A Win for Life^{SM} top prize of $1,000 per week for life is based on the unknown duration of the life of the prize winner and is therefore a prize of unspecified value and uncertain periodicity. Consequently, a Win for Life^{SM} top prize of $1,000 per week for life is not a future periodic prize payment as described in ORS 461.253(1) and cannot be assigned, gifted, sold, or transferred in any manner from the winner to another person or entity except under the circumstances as described in subsection (d) of this rule.

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

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461

Stats. Implemented: ORS 461

Hist.: LOTT 11-2000, f. & cert. ef. 12-1-00; LOTT 1-2001(Temp), f. & cert. ef. 1-22-01 thru 7-21-01; LOTT 7-2001, f. 4-25-01, cert. ef. 4-26-01; LOTT 8-2002(Temp), f. & cert. ef. 7-15-02 thru 1-3-03; LOTT 20-2002, f. & cert. ef. 9-30-02; LOTT 11-2010, f. 11-19-10, cert. ef. 12-1-10; LOTT 4-2012(Temp), f. & cert. ef. 6-29-12 thru 12-21-12; LOTT 8-2012, f. 11-30-12, cert. ef. 12-16-12; LOTT 4-2016(Temp), f. 7-14-16, cert. ef. 8-9-16 thru 1-31-17

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Oregon State Marine Board
Chapter 250

Rule Caption: Amend Steering and Sailing Rules to be compliant with Federal Regulations
Adm. Order No.: OSMB 7-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 250-011-0050, 250-011-0060
Rules Repealed: 250-011-0050(T), 250-011-0060(T)
Subject: This action will amend the Steering and Sailing administrative rules to remove language that is in conflict with federal regulations 33CFR 83 Subpart B to ensure consistency between federally navigable waters and exclusive state waters.
Rules Coordinator: June LeTarte—(503) 378-2617

250-011-0050
Conduct of Vessels in Any Condition of Visibility

(1) Every vessel shall at all times maintain a proper lookout by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and of the risk of collision.

(2) Every vessel shall at all times proceed at a safe speed so that it can take proper and effective action to avoid collision and be stopped within a distance appropriate to the prevailing circumstances and conditions. In determining a safe speed the following factors shall be among those taken into account by all vessels:

(a) The state of visibility;

(b) The traffic density including concentration of fishing vessels or any other vessels;

(c) The maneuverability of the vessel with special reference to stopping distance and turning ability in the prevailing conditions;

(d) At night the presence of background light such as from shore lights or from back scatter of its own lights;

(e) The state of wind, sea, and current, and the proximity of navigational hazards;

(f) The draft in relation to the available depth of water;

(g) The characteristics, efficiency and limitations of the radar equipment;

(h) Any constraints imposed by the radar range scale in use;

(i) The effect on radar detection of the sea state, weather, and other sources of interference;

(j) The possibility that small vessels, ice and other floating objects may not be detected by radar at an adequate range;

(k) The number, location, and movement of vessels detected by radar; and

(l) The more exact assessment of the visibility that may be possible when radar is used to determine the range of vessels or other objects in the vicinity.

(3) Every vessel shall use all available means appropriate to the prevailing circumstances and conditions to determine if risk of collision exists. If there is any doubt such risk shall be deemed to exist. Proper use shall be made of radar equipment if fitted and operational, including long-range scanning to obtain early warning of risk of collision and radar plotting or equivalent systematic observation of detected objects. Assumptions shall not be made on the basis of scanty information, especially scanty radar information. In determining if risk of collision exists the following considerations shall be among those taken into account:

(a) Such risk shall be deemed to exist if the compass bearing of an approaching vessel does not appreciably change; and

(b) Such risk may sometimes exist even when an appreciable bearing change is evident, particularly when approaching a very large vessel or a tow or when approaching a vessel at close range.

(4) Any action taken to avoid collision shall be taken in accordance with OAR 250-011-0050, 250-011-0060, 250-011-0070 and shall, if the circumstances of the case admit, be positive, made in ample time and with due regard to the observance of good seamanship.

(a) Any alteration of course or speed to avoid collision shall, if the circumstances of the case admit, be large enough to be readily apparent to another vessel observing visually or by radar; a succession of small alterations of course or speed should be avoided.

(b) If there is sufficient sea room, alteration of course alone may be the most effective action to avoid a close-quarters situation provided that it is made in good time, is substantial and does not result in another close-quarters situation.

(c) Action taken to avoid collision with another vessel shall be such as to result in passing at a safe distance. The effectiveness of the action shall be carefully checked until the other vessel is finally past and clear.

(d) If necessary to avoid collision or allow more time to assess the situation, a vessel shall slacken its [speed or take all way off by stopping or reversing its means of propulsion.

(e) A vessel, which, by any of these rules is required not to impede the passage or safe passage of another vessel shall, when required by the circumstances of the case, take early action to allow sufficient sea room for the safe passage of the other vessel.

(A) A vessel required not to impede the passage or safe passage of another vessel is not relieved of this obligation if approaching the other vessel so as to involve risk of collision and shall, when taking action, have full regard to the action which may be required by OAR 250-011-0050, 250-011-0060, and 250-011-0070.

(B) A vessel the passage of which is not to be impeded remains fully obliged to comply with OAR 250-011-050, 250-011-0060, and 250-011-0070 when the two vessels are approaching one another so as to involve risk of collision.

(5) A vessel proceeding along the course of a narrow channel or fairway shall keep as near to the outer limit of the channel or fairway which lies on its starboard side as is safe and practicable:

(a) A vessel of less than 20 meters in length or a sailing vessel shall not impede the passage of a vessel that can safely navigate only within a narrow channel or fairway;

(b) A vessel engaged in fishing shall not impede the passage of any other vessel navigating within a narrow channel or fairway;

(c) A vessel shall not cross a narrow channel or fairway if such crossing impedes the passage of a vessel which can safely navigate only within that channel or fairway. The latter vessel shall use the danger signal prescribed in OAR 250-011-0200(4) if in doubt as to the intention of the crossing vessel;

(d) In a narrow channel or fairway when overtaking, the vessel intending to overtake shall indicate its intention by sounding the appropriate signal prescribed in OAR 250-011-0200(3)(a) and(b), and take steps to permit safe passing. The overtaken vessel, if in agreement, shall sound the same signal. If in doubt it shall sound the danger signal prescribed in OAR 250-011-0200(4). This does not relieve the overtaking vessel of its obligation under OAR 250-011-0060(2);

(e) A vessel nearing a bend or an area of a narrow channel or fairway where other vessel may be obscured by an intervening obstruction shall navigate with particular alertness and caution and shall sound the appropriate signal prescribed in OAR 250-011-0200(5);

(f) Every vessel shall, if the circumstances of the case admit, avoid anchoring in a narrow channel.

(6) Any vessel approaching, overtaking, being approached, or being overtaken by a moving law enforcement vessel operating with a siren or an illuminated flashing blue light, or any vessel approaching a stationary law enforcement vessel displaying an illuminated blue light, shall:

(a) Immediately slow to a speed sufficient to maintain steerage only, shall alter its course, within its ability, so as not to inhibit or interfere with the operation of the law enforcement vessel, and shall proceed, unless otherwise directed by the operator of the law enforcement vessel, at the reduced speed until beyond the area of operation of the law enforcement vessel;

(b) Notwithstanding the operational requirements of section 6 (a) of this rule, vessels shall not be required to operate in a manner that would endanger or be likely to endanger that craft, other nearby watercraft, or other persons or property.

Stat. Auth.: ORS 830.110 & 830.175
Stats. Implemented: ORS 830.335 & 830.340
Hist.: MB 14-1983, f. 11-29-83, ef. 12-1-83; MB 4-1993, f. & cert. ef. 3-16-93; Renumbered from 250-011-0005, OSMB 5-2015, f. 6-26-15, cert. ef. 7-1-15; OSMB 4-2016(Temp), f. & cert. ef. 5-2-16 thru 8-31-16; OSMB 7-2016, f. 6-30-16, cert. ef. 7-1-16

250-011-0060
Conduct of Vessels in Sight of One Another

(1) When two sailing vessels are approaching one another, so as to involve risk of collision, one of them shall keep out of the way of the other as follows:

(a) When each has the wind on a different side, the vessel which has the wind on the port side shall keep out of the way of the other;

(b) When both have the wind on the same side, the vessel which is to windward shall keep out of the way of the vessel which is to leeward; and

(c) If a vessel with the wind on the port side sees a vessel to windward and cannot determine with certainty whether the other vessel has the wind on the port or on the starboard side, it shall keep out of the way of the other;

(d) For the purpose of this section the windward side shall be deemed to be the side opposite to that on which the mainsail is carried or, in the case of a square-rigged vessel, the side opposite to that on which the largest fore-and-aft sail is carried.

(2) Notwithstanding anything contained in OAR 250-011-0050 through 250-011-0060 any vessel overtaking any other shall keep out of the way of the vessel being overtaken. A vessel shall be deemed to be overtaking when coming up with another vessel from a direction more than 22.5 degrees abaft its beam; that is, in such a position with reference to the vessel it is overtaking, that at night it would be able to see only the sternlight of that vessel but neither of its sidelights. When a vessel is in any doubt as to whether it is overtaking another, it shall assume that this is the case and act accordingly. Any subsequent alteration of the bearing between the two vessels shall not make the overtaking vessel a crossing vessel within the meaning of these rules or relieve it of the duty of keeping clear of the overtaken vessel until it is finally past and clear.

(3) Unless otherwise agreed, when two power-driven vessels are meeting on reciprocal or nearly reciprocal courses so as to involve risk of collision each shall alter its course to starboard so that each shall pass on the port side of the other. Such a situation shall be deemed to exist when a vessel sees the other ahead or nearly ahead and by night it could see the masthead lights of the other in a line or nearly in a line or both sidelights and by day it observes the corresponding aspect of the other vessel. When a vessel is in any doubt as to whether such a situation exists it shall assume that it does exist and act accordingly.

(4) When two power-driven vessels are crossing so as to involve risk of collision, the vessel which has the other on its starboard side shall keep out of the way and shall, if the circumstances of the case admit, avoid crossing ahead of the other vessel.

(5) Every vessel which is directed to keep out of the way of another vessel shall, so far as possible, take early and substantial action to keep well clear.

(6) Where one of two vessels is to keep out of the way, the other shall keep its course and speed:

(a) The latter vessel may, however, take action to avoid collision by its maneuver alone, as soon as it becomes apparent to it that the vessel required to keep out of the way is not taking appropriate action in compliance with these rules;

(b) When, from any cause, the vessel required to keep its course and speed finds itself so close that collision cannot be avoided by the action of the give-way vessel alone, it shall take such action as will best aid to avoid collision. A power-driven vessel which takes action in a crossing situation in accordance with section (7)(a) of this rule to avoid collision with another power-driven vessel shall, if the circumstances of the case admit, not alter course to port for a vessel on its own port side. This rule does not relieve the give-way vessel of its obligation to keep out of the way.

(7) Except where OAR 250-011-0050(5) and section (2) of this rule otherwise require:

(a) A power-driven vessel underway shall keep out of the way of:

(A) A vessel not under command;

(B) A vessel restricted in its ability to maneuver;

(C) A vessel engaged in fishing; and

(D) A sailing vessel.

(b) A sailing vessel underway shall keep out of the way of:

(A) A vessel not under command;

(B) A vessel restricted in its ability to maneuver; and

(C) A vessel engaged in fishing.

(c) A vessel engaged in fishing when underway shall, so far as possible, keep out of the way of:

(A) A vessel not under command; and

(B) A vessel restricted in its ability to maneuver.

Stat. Auth.: ORS 830
Stats. Implemented: ORS 830.110
Hist.: MB 14-1983, f. 11-29-83, ef. 12-1-83; MB 1-1985, f. & ef. 1-29-85; Renumbered from 250-011-0010, OSMB 5-2015, f. 6-26-15, cert. ef. 7-1-15; OSMB 4-2016(Temp), f. & cert. ef. 5-2-16 thru 8-31-16; OSMB 7-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Long term and unoccupied moorage restrictions on lakes in Jefferson County
Adm. Order No.: OSMB 8-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Amended: 250-020-0161
Subject: This rule will prevent long term mooring of boats on all lakes in Jefferson County, ensure boats are not left unattended and preserve unrestricted water access for all users.
Rules Coordinator: June LeTarte—(503) 378-2617

250-020-0161
Boat Operations in Jefferson County

(1) No person shall operate a motorboat for any purpose on the following lakes:

(a) Scout;

(b) Round;

(c) Jack;

(d) Island;

(e) Cache;

(f) Hand and

(g) Link.

(2) Suttle Lake:

(a) No water skiing or motorboat operation in excess of 10 MPH to be permitted on Suttle Lake between the hours of 8 p.m. and 9 a.m., standard time, each day;

(b) No water skiing or motorboat operation in excess of 10 MPH to be permitted on Suttle Lake between the hours of 9 a.m. and 8 p.m., standard time, each day, except within the signed and designated fast boat area, water skier dropoff zone, and water skier take-off lanes, at the west end of the lake;

(c) Operating any boat which is equipped with a toilet is prohibited on Suttle Lake, unless such toilet has an approved device to render waste harmless, or unless such toilet is rendered inoperative by having the discharge outlet effectively sealed.

(3) Lake Simtustus:

(a) No person shall operate a motorboat in excess of a "slow—no wake" speed in the area within 300 feet of the moorage and extending to the opposite shore;

(b) No person shall operate a boat for any reason within the restricted tailrace area enclosed by the log boom approximately 1200 feet downstream of Round Butte Dam;

(c) No person shall moor a boat to the log boom or operate a boat for any reason within the restricted intake area enclosed by the log boom located approximately 200 feet upstream of Pelton Dam;

(d) Boat access in the areas closed by subsections (b) and (c) of this section is permitted for federal, state, local and tribal government agencies and Portland General Electric employees or their agents for official business only.

(4) Lake Billy Chinook:

(a) No person shall operate motorboat in excess of 10 MPH in the following areas:

(A) On the Crooked River Arm above the Crooked River Bridge.

(B) On the Deschutes River Arm above the Deschutes River Bridge;

(C) On the Metolius River Arm from a point approximately 1,000 feet upstream of Street Creek, as marked.

(b) No person shall operate a motorboat in excess of a "slow—no wake" speed within the buoyed areas at:

(A) Cove Palisades State Park Marina;

(B) The Crooked River Launching Ramp;

(C) The Lower Deschutes River Day Use Area;

(D) The Upper Deschutes River Day Use Area;

(E) Within 300 feet of a designated swimming area;

(F) Within a cove at Chinook Island (Metolius Arm) as marked;

(G) Within the cove at Camp Perry South (Metolius Arm) as marked.

(c) No person shall operate a boat inside the log boom enclosure around Round Butte Dam.

(5) No person shall beach, anchor or moor a boat within 200 feet of shore in the following areas at Lake Billy Chinook between 10 p.m. and 5 a.m.

(a) Crooked River Arm:

(A) East shore — between a point approximately 1,000 feet north of the cove Marina, as marked, and the Crooked River Bridge;

(B) West Shore — From the State Park boundary north approximately 2,000 feet, as marked.

(b) Deschutes Arm: East Shore — Between a point approximately 2,000 feet north of the northernmost boat launch, as marked, and the Deschutes River Bridge;

(c) This prohibition shall not apply to any leased or rented space within established marinas or moorages.

(6) No person shall operate or provide for others to operate a boat on Lake Billy Chinook which is equipped with a marine toilet, unless the toilet has a holding tank or is rendered inoperative so as to prevent any overboard discharge.

(7) Haystack Reservoir. No person shall operate a boat in excess of 5 MPH in the following areas:

(a) In the western cove inside a buoy line approximately 500 feet from shore, as marked;

(b) In the southern cove inside a buoy line extending from south of the boat ramp on the east shore to a point south of the southeast peninsula, as marked.

(8) For all lakes in Jefferson County:

(a) The owner or operator of a boat that has been anchored or moored outside of a marina or away from a dock:

(A) For 30 consecutive days in one location must move the boat to a new location at least one half mile away and must not return to the previously used location for 30 days. For the purpose of this rule, "location" is defined as an area within a 300 foot radius.

(B) Must not leave the boat unattended for more than 7 consecutive days.

(b) Subsection (a) does not apply to a person anchoring or mooring a boat on privately owned submerged or submersible land with the permission of the landowner.

(c) An unattended boat adrift may be considered a "derelict vessel" as defined in ORS 830.908(3) and may be subject to seizure.

Stat. Auth.: ORS 830.110, 830.175 & 830.195
Stats. Implemented: ORS 830.110 & 830.175
Hist.: MB 43, f. 7-18-69; MB 58, f. 7-2-74, ef. 7-2-74(Temp) & 7-25-74(Perm); Renumbered from 250-020-0200; MB 16-1985, f. & ef. 10-21-85; MB 8-1986, f. & ef. 7-28-86; MB 11-1986, f. & ef. 10-30-86; MB 6-1987, f. 4-20-87, ef. 5-1-87; MB 4-1990, f. & cert. ef. 7-13-90; MB 10-1992, f. & cert. ef. 8-21-92; MB 7-1993, f. & cert. ef. 10-11-93; MB 8-1994(Temp), f. & cert. ef. 6-17-94 thru 12-17-94; MB 10-1994, f. & cert. ef. 9-28-94; OSMB 2-2004(Temp), f. & cert. ef. 5-20-04 thru 9-20-04; Administrative correction 10-25-04; OSMB 6-2006, f. & cert. ef. 7-3-06; OSMB 10-2007(Temp), f. & cert. ef. 9-4-07 thru 12-31-07; OSMB 12-2007, f. & cert. ef. 10-1-07; OSMB 4-2015, f. 4-30-15, cert. ef. 5-1-15; OSMB 8-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Repeal titling issuance fee rule and amend refund fee rule.
Adm. Order No.: OSMB 9-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 250-010-0058
Rules Repealed: 250-010-0057(T)
Subject: Repeal rule language already identified in Oregon Revised Statute and amend the price point which automatically generates an overpayment refund.
Rules Coordinator: June LeTarte—(503) 378-2617

250-010-0057
Issuance and Duplication Fees

(1) Fees for the title issuance and duplication fee shall be:

(a) Title original issuance — $30;

(b) Title duplication without change when original has been lost, mutilated, destroyed or stolen — $15;

(c) Title reissued with change of ownership — $30.

(2) Fees for duplication of certificate of number, certificate or registration and/or duplication of validation stickers — $10. The agency shall waive the fee for duplicate decal if the original decal issued is found to be defective.

Stat. Auth.: ORS 830
Stats. Implemented: ORS 830.110 & 830.820
Hist.: MB 19-1983, f. 11-29-83, ef. 12-1-83; OSMB 1-2002, f. 4-15-02 cert. ef. 6-1-02; OSMB 6-2002, f. & cert. 10-15-02; OSMB 1-2005, f. & cert. ef. 1-20-05; Suspended by OSMB 3-2016(Temp), f. & cert. ef. 4-13-16 thru 7-31-16; Temp repealed by OSMB 9-2016, f. 6-30-16, cert. ef. 7-1-16

250-010-0058
Refunds

(1) Pursuant to ORS 293.445(4), the Board will refund amounts more than $10 when it determines that moneys have been received in excess of the amount legally due the Board.

(2) If the refund amount owed is $10 or less, a refund shall be paid upon receipt of a written request from the person who paid the money or their legal representative.

Stat. Auth.: ORS 293 & 830
Stats. Implemented: ORS 830.110
Hist.: MB 9-1986, f. 7-28-86, ef. 8-1-86; OSMB 1-2002, f. 4-15-02 cert. ef. 6-1-02; OSMB 9-2016, f. 6-30-16, cert. ef. 7-1-16

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Rule Caption: Prohibit motorboats on Kinney Lake in Wallowa County
Adm. Order No.: OSMB 10-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 6-1-2016
Rules Amended: 250-020-0340
Subject: No person shall operate a motorboat on Kinney Lake in Wallowa County.
Rules Coordinator: June LeTarte—(503) 378-2617

250-020-0340
Boat Operations in Wallowa County

(1) Wallowa Lake. No person shall operate a boat in excess of 5 MPH within 200 feet from shore along the west side of Wallowa Lake in the area bounded by the county boat ramp on the north and the mouth of the Wallowa River on the south.

EXCEPTION: Boats towing water skiers may exceed 5 MPH on safe take offs and landings. A "safe" take-off or landing is one without risk to any swimmer or craft within 200 feet from shoreline.

(2) Snake River. No person, other than a member of the Department of State Police, county sheriff, and governmental agencies of this state and the federal government having jurisdiction over the following described waters, shall use a motor for propelling a boat for any purpose on the Snake River between Wild Sheep Rapid and Kirkwood Historic Ranch without a valid permit from the Hells Canyon National Recreation Area or Wallowa-Whitman National forest.

(3) Grande Ronde River. No person, other than a member of the Oregon State Police, county sheriff, and governmental agencies of this state, and agencies of the federal government having jurisdiction over the following described waters, shall use a motor to propel a boat for any purpose on the Grande Ronde River between the Umatilla National Forest Boundary (1.5 miles below the confluence with the Wallowa River at approximately RM 80) downstream to the Oregon/Washington state line; except for landowner access for land management activities.

(4) No person shall operate a motorboat on Kinney Lake.

Stat. Auth.: ORS 830
Stats. Implemented: ORS 830.110 & 830.175
Hist.: MB 3-1985, f. & ef. 1-29-85; MB 3-1995, f. & cert. ef. 5-31-95; OSMB 10-2016, f. 6-30-16, cert. ef. 7-1-16

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Oregon State Treasury
Chapter 170

Rule Caption: Modifies advance and current forward refunding rule requirements and updates Municipal Advisor requirements.

Adm. Order No.: OST 4-2016
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 6-30-16
Notice Publication Date: 3-1-2016
Rules Amended: 170-062-0000
Subject: This amendment (1) provides greater clarity on documents required for submission when applying for advance and current refunding approval and (2) simplifies the municipal advisor definition.
Rules Coordinator: Dan McNally—(503) 373-1028

170-062-0000
Procedure for Submission, Review and Approval of an Advance Refunding Plan or Forward Current Refunding Plan

(1) Plan Contents and Filing. Every public body (as defined in ORS 287A.001(14) must submit its plans for an advance refunding or forward current refunding (the "Refunding Plan") and receive approval of the Refunding Plan by the Office of the State Treasurer ("OST") prior to the sale of bonds connected to the Refunding Plan, as provided in this rule and ORS287A.365. The Refunding Plan request should include the name, phone number, U.S. mailing and e-mail address for the public body and for the public body's bond counsel, Municipal Advisor ("MA"), and underwriter. The Refunding Plan must contain:

(a) A statement of purpose of the Refunding Plan;

(b) A description of the bonds to be refunded, including: date and premium, if any, when each is first callable; par amount originally issued, current amount outstanding, proposed amount and maturities to be refunded; and the dated date;

(c) A preliminary estimate of the Net Present Value Savings ("NPVS"): Present value savings is defined as the present value of the difference in debt service between the proposed refunded debt service and the proposed refunding debt service, discounted at the arbitrage yield of the refunding debt service. Any issuance expenses paid from sources other than bond proceeds and any other cash contributed to the escrow other than from bond proceeds must also be subtracted from proceeds to determine NPVS;

(d) A copy of the authorizing Ordinance/Resolution;

(e) A copy of the contract between the public body and its MA;

(f) Completed Municipal Debt Advisory Committee ("MDAC") Form 1;

(g) Estimated costs of issuance for the MA, bond counsel and underwriting costs;

(h) Final Official Statement and Bond Purchase Agreement, if applicable;

(i) Final Net Present Value Savings as described in subsection (c) of this section;

(j) Final version of Issuer's Arbitrage/Tax Certificate;

(k) Escrow verification report;

(l) Copy of the letter from MA to the public body as described in section (2) of this rule;

(m) Completed MDAC Form 2;

(n) Completed MDAC Form 3, if using a synthetic fixed rate refunding issue;

(o) Final Draft of Bond Counsel Legal Opinion with Executed version provided within 5 business days of Closing; and

(p) Any additional materials that may be required by OST in support of the Advance Refunding or Forward Current Refunding request.

(2) Municipal Advisor required.

(a) A public body must employ an independent registered MA whose function is to advocate for the public body and advise them on the refinancing transaction that is the subject of the Refunding Plan. The MA must be registered with the Securities and Exchange Commission as required under 17 CFR § 240.15Ba1-2. The MA may not also serve as the underwriter in the same negotiated bond sale as required in Rule G23 of the Municipal Securities Rulemaking Board.

(b) Prior to closing, the public body and the OST must receive from the MA a letter stating that the MA:

(A) is currently registered with the SEC as an MA and meets the requirements in subsection (2)(a) above;

(B) has reviewed the assumptions included in the Refunding Plan; and

(C) has provided a recommendation on the desirability or undesirability of completing the Refunding Plan and the reasons therefor. Forward current Refunding Plans must also include a description of the suitability of the public body for conducting a forward current refunding and an estimate in basis points of the premium paid to execute the forward refunding.

(3) OST Approval Procedure.

(a) Preliminary Approval. If the items in subsections (1)(a) through (1)(g) of this rule are completed and submitted to OST, then OST will notify the public body of OST's preliminary approval and state its intention to issue a final approval conditioned upon receipt and approval of items in subsections (1)(h) through (1)(p) of this rule;

(b) Preliminary Refunding Plans should be submitted to OST sufficiently in advance to allow 10 working days for review. The 10-day review period begins the working day after all items (1)(a) through (1)(g) of this rule and the application fee identified in OAR 170-061-0015 have been received;

(c) Preliminary approval is valid for a period of one year from the date of the preliminary approval letter. After the one year period expires, a new application fee and Refunding Plan are required;

(d) Final Approval. If the items in subsections (1)(h) through (1)(p) of this rule are received and approved by OST, then OST will issue its final approval for the Refunding Plan within five working days. The five-day period begins after receipt of all items required for final approval; and

(e) At the discretion of OST, drafts of preliminary and final components of Refunding Plans may be accepted and reviewed in lieu of finalized documents with the understanding that finalized documents will be provided within five working days of the bond closing.

(4) Administrative Expenses. To reimburse OST for the services, duties and activities of OST in connection with reviewing the plan, fees and expenses will be charged to public bodies as identified in OAR 170-061-0015.

(5) Ongoing Evaluation. OST evaluates long term trends in Oregon debt issuance. Adverse trends associated with local government refundings may result in a review and revision of the factors used by OST to evaluate refundings with the goal of diminishing potential undesirable impacts upon the higher priority "new money" bond issues.

(6) Waiver of Certain Provisions. OST may waive certain provisions of this rule to accommodate unusual circumstances.

(7) Noncompliance. If OST finds that the Preliminary Refunding Plan is not in substantial compliance with ORS 287A and this rule, the plan may not be approved. Notice that the plan does not comply, and the reasons for this finding will be sent to the public body and its bond counsel within 10 business days after receipt of the plan.

(8) Submission. Refunding Plans should be submitted to OST as provided in OAR 170-055-0001(4).

(9) Through its review and approval or disapproval of a Refunding Plan, OST is not acting as a fiduciary or municipal advisor to a public body, is not providing advice with respect to the structure, timing, terms or other similar matters concerning the Refunding Plan and expects the public body to rely on the advice of its MA with respect to such matters.

[Publications: Publications referenced are available from the Agency.]
Stat. Auth.: ORS 287A.365
Stats. Implemented: ORS 287A.360 - 287A.380
Hist.: TD 2-1986, f. & ef. 6-16-86; TD 2-1990, f. 9-18-90, cert. ef. 9-19-90; TD 2-1994, f. & cert. ef. 9-9-94; OST 5-2004, f. & cert. ef. 6-23-04; OST 2-2006, f. & cert. ef. 8-4-06; OST 7-2008, f. & cert. ef. 12-29-08; OST 5-2010(Temp), f. 11-29-10, cert. ef. 12-1-10 thru 5-29-11; OST 2-2011, f. & cert. ef. 4-1-11; OST 2-2012(Temp), f. & cert. ef. 11-19-12 thru 5-15-13; Administrative correction, 6-27-13; OST 2-2015, f. & cert. ef. 7-10-15; OST 1-2016, f. & cert. ef. 2-10-16; OST 4-2016, f. & cert. ef. 6-30-16

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Oregon Tourism Commission
Chapter 976

Rule Caption: Amend Wine Country License Plate rule as required by ORS 805.274
Adm. Order No.: ORTC 1-2016
Filed with Sec. of State: 6-29-2016
Certified to be Effective: 7-1-16
Notice Publication Date: 5-1-2016
Rules Amended: 976-002-0020
Subject: (3) The guidelines established by the Oregon Tourism Commission shall include the requirement that tourism promotion agencies collaborate with the Oregon Wine Board and relevant regional winery associations whenever the tourism promotion agencies develop expenditure plans for money distributed.
Rules Coordinator: Sarah Watson—(503) 967-1568

976-002-0020
Tourism Promotion Guidelines

(1) The Oregon Tourism Commission shall prepare guidelines each biennium applicable to Tourism Promotion Distribution to be awarded under ORS 805.274(1)(b). The guidelines shall be available from the Oregon Tourism Commission and shall be published on the Oregon Tourism Commission's website.

(2) The Oregon Tourism Commission will designate a tourism promotion agency for each region to receive the moneys described in ORS 805.274(1)(b).

(3) The guidelines established by the Oregon Tourism Commission shall include the requirement that tourism promotion agencies collaborate with the Oregon Wine Board and relevant regional winery associations whenever the tourism promotion agencies develop expenditure plans for money distributed.

Stat. Auth.: ORS 284.111(6), ORS 805.274(3)
Stats. Implemented: ORS 805.274
Hist.: ORTC 1-2015, f. 2-17-15, cert. ef. 3-1-15; ORTC 1-2016, f. 6-29-16, cert. ef. 7-1-16

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Parks and Recreation Department
Chapter 736

Rule Caption: Amend Special Access Pass Rules
Adm. Order No.: PRD 3-2016
Filed with Sec. of State: 7-13-2016
Certified to be Effective: 7-13-16
Notice Publication Date: 5-1-2016
Rules Amended: 736-015-0010, 736-015-0015, 736-015-0026, 736-015-0035
Subject: Recent revisions to the special access pass rules made changes that allowed booking sites on-line with the discount. There is a ten day per month limit on the benefit. When we revised the rules we stated that as ten days in a calendar month however our software uses a rolling month, so a rule change is necessary to line up the rules with actual practice. This revision will change the time frame for using the overnight rental fee waiver from "calendar month" to a "30-day period."

Recent changes to the OPRD agency structure have resulted in changes to some position titles and office names. There are housekeeping revisions included in this rulemaking that change those terms in the rules that no longer match the current terms used by OPRD.
Rules Coordinator: Claudia Ciobanu—(503) 872-5295

736-015-0010
General Regulations

(1) The commission shall establish fees through rule to promote department financial self-sufficiency and based on the following criteria:

(a) Prevailing rates for comparable facilities;

(b) Day of week;

(c) Season of year;

(d) Amenities of the park area and site;

(e) Marketing opportunities to encourage use and revenues.

(2) Unless posted otherwise, a person shall pay established rates prior to use.

(3) The director may establish rates and rental charges for services, facilities and products that are optional, nonessential or complement the basic services described in this division. The director shall establish rates that take into consideration comparable services by other providers and marketing opportunities to encourage use and revenues.

(4) Pursuant to ORS 105.672 to 105.696, fees charged under this division are for use of the assigned area or park facility of the state park land for camping, picnicking, or boating and not for any other recreational purpose or area of state park land. The immunities provided under ORS 105.682 apply to use of state park land for any other recreational purpose.

Stat. Auth.: ORS 390.124
Stats. Implemented: ORS 390.111, 390.121 & 390.124
Hist.: 1 OTC 56(Temp), f. & ef. 4-4-75; 1 OTC 59, f. 8-1-75, ef. 8-25-75; 1 OTC 74, f. & ef. 4-30-76; 1 OTC 82, f. 5-11-77, ef. 5-14-77; 1 OTC 5-1979, f. & ef. 2-9-79; 1 OTC 22-1979 (Temp), f. & ef. 9-24-79; 1 OTC 2-1980, f. & ef. 1-4-80; PR 9-1981, f. & ef. 4-6-81; PR 5-1983, f. & ef. 3-30-83; PR 10-1983(Temp), f. & ef. 12-28-83; PR 3-1984, f. & ef. 3-5-84; PR 11-1986, f. & ef. 7-9-86; PR 1-1990, f. & cert. ef. 5-14-90; PR 4-1991, f. 4-30-91, cert. ef. 5-13-91; PR 1-1992, f. & cert. ef. 2-14-92; PR 13-1993, f. 7-12-93, cert. ef. 8-2-93; PR 7-1994, f. & cert. ef. 7-11-94; PR 2-1995, f. & cert. ef. 1-23-95; PR 3-1996, f. & cert. ef. 5-13-96; PRD 8-2004, f. & cert. ef. 6-3-04; Renumbered from 736-010-0098, PRD 4-2005, f. & cert. ef. 5-5-05; PRD 7-2007, f. & cert. ef. 8-28-07; PRD 6-2010(Temp), f. & cert. ef. 4-15-10 thru 10-8-10; Administrative correction 10-26-10; PRD 7-2011, f. & cert. ef. 11-28-11; PRD 3-2016, f. & cert. ef. 7-13-16

736-015-0015
Reservations

(1) Purpose: Based on the department's goal to promote outdoor recreation in Oregon, the department established a reservation program to increase use of park areas and facilities. The director may designate specific park facilities to offer for reservation through a centralized call center and through the Internet.

(2) General Regulations:

(a) Reservations will be accepted and processed for designated park facilities through the Oregon State Parks Reservation Center and the Internet.

(b) A person may make a reservation a minimum of one day and a maximum of nine months prior to the arrival date.

(c) A person must be 18 years of age or older to make a reservation.

(d) A person who qualifies under the Americans with Disabilities Act (ADA) may reserve accessible campsites.

(e) A person may not make reservations for multiple park areas for the same date range.

(f) A person reserving a boat slip (where available) must also reserve another facility at the same park area.

(g) Reservations and registrations for horse camping sites shall be made only for people camping with their horses or similar large animals unless otherwise specified by the park manager.

(h) Split reservations are allowed to accommodate persons. Only one split reservation shall be allowed per reservation. The department may waive one reservation fee for every reservation fee paid. A split reservation may only be made through the Oregon State Parks Reservation Center. Reservations made on the Internet are not eligible for this fee waiver.

(i) Only the person whose name appears on the original reservation or their designee (as documented in the reservation records) may change or cancel an existing reservation or access information associated with a reservation.

(j) Customer information may be made available upon written request in compliance with ORS chapter 192 and department policy.

(k) Specific information regarding a confirmed reservation will not be released to the public as provided in ORS 192.501 and 192.502.

(3) Transaction Fees and Deposits:

(a) The department will charge an $8 non-refundable transaction fee for each reservation made through the centralized call center or the Internet.

(b) Reservations require a facility deposit equal to the full amount charged for use of the facility during the reservation period.

(c) All fees are due at the time the person makes the reservation.

(4) Payment Methods:

(a) A person may use a valid credit card (VISA or MasterCard) or bank debit card with a VISA or MasterCard logo.

(b) A person may pay for reservations made through the Oregon State Parks Reservation Center by personal check, money order, certified check, department issued gift certificates or travelers check (in U.S. funds). These forms of payment are not accepted for reservations made on the Internet.

(c) The department must receive payment within five calendar days of the date the person makes the reservation. If payment is not received within this time frame, the department will cancel the reservation. The person remains responsible for the $8 transaction fee for each reservation request.

(d) If a banking institution returns a check to the department for any reason or if a credit or debit card is declined, the department will attempt to contact the person. Inability to resolve the payment dispute will result in a reservation cancellation. The person will remain responsible for the $8 transaction fee for each reservation.

(e) Government agencies and non-profit entities may request to be invoiced for services. Reservations should be made at least 30 days prior to arrival. The department must receive payment within 25 days of the date the reservation is made. If payment is not received the department will cancel the reservation. The department will bill for the $8 transaction fee for each reservation.

(f) A person must pay all outstanding account balances prior to making future reservations.

(5) Reservation Cancellations:

(a) A person may cancel their reservation prior to the day of arrival by calling the Oregon State Parks Reservation Center. An automated reservation cancellation voice mail system is available seven days a week, 24 hours a day.

(b) A person may also cancel their reservation prior to the day of arrival using Internet or E-mail. The department will post detailed instructions for cancelling a reservation on the department's web site which is available seven days a week, 24 hours a day.

(c) A person may contact the specific park where their reservation is held to cancel reservations on the scheduled day of arrival.

(d) In order to receive a refund of all use fees, a person must cancel the reservation for individual campsites, deluxe and rustic cabins, deluxe and rustic yurts, horse camps, tepees, and boat moorages three or more days prior to the arrival date. If the cancellation is received less than three days in advance of the arrival date, a fee equal to one overnight rental fee for the facility will be forfeited.

(e) In order to receive a refund of all use fees for group camps, day use areas, meeting halls, lodges, Silver Falls Youth Camp, Silver Falls Ranch, Shore Acres Garden House, Pavilions, RV Group Areas and other special facilities as designated by the department, a person must cancel the reservation at least one month prior to arrival. If the cancellation request is received less than one month in advance of the arrival date, a fee equal to one night's or one day's rental for the facility will be forfeited.

(6) Reservation Changes:

(a) The department will charge an $8 non-refundable transaction fee for each reservation change.

(b) A person may request to change a confirmed reservation by calling the Oregon State Parks Reservation Center during normal business hours Monday through Friday.

(c) A person may not make any date changes to reservations more than eight months in advance of the arrival date.

(d) Reservations made for six or more consecutive nights that are later shortened will be charged the nightly rate for each night removed in addition to an $8 transaction fee for the change.

(e) A person must request a reservation change for campsites, deluxe and rustic cabins, deluxe and rustic yurts, tepees, and boat moorages three or more days in advance of the arrival date. Changes are not permitted within three days of the arrival date.

(f) A person requesting a reservation change for group camps, day use areas, meeting halls, lodges, Silver Falls Youth Camp, Silver Falls Ranch House, Shore Acres Garden House, Pavilions, RV Group Areas, and other special facilities as designated by the department must request the change at least one month prior to arrival date. Changes are not permitted within one month of the arrival date.

(7) Claiming Reservations

(a) Customers with confirmed reservations must arrive before 1:00 p.m. the day following the first scheduled day of their reservation.

(b) The reserved site must remain occupied each night during the entire length of stay.

(c) In emergency situations, customers may request Park Manager approval for late arrivals not to exceed 6:00 p.m. of the second day of the reservation. Site fees for the first night will be charged regardless of the arrival time.

(d) Customers, including those that have pre-registered, who do not check in at the park or notify park staff that they will be delayed prior to 1:00 p.m. of the second day of the reservation will be considered a "no show" and the entire reservation will be cancelled. The first night fee and any transaction fees previously collected for the reservation will be retained. Any remaining nightly fees paid to confirm the reservation will be refunded.

(8) Reservations to Accommodate Organized Groups:

(a) General: To accommodate group use in campgrounds designed primarily for individual camping and to bring efficiencies to the group reservation process, the director may offer group camping to persons reserving multiple individual camping sites.

(b) The department will require full payment for all sites at the time the reservation is made.

(c) A person must reserve a minimum of 20 individual overnight campsites for their group to qualify for group camping reservations.

(d) The department will charge a non-refundable reservation fee of $8 for each site. An $8 non-refundable transaction fee will be charged for any date or site change made to a reservation included in the group.

(e) Reservations made on the Internet for a group of 20 or more sites are not eligible for group camping.

(f) A person may reserve a meeting hall (where available) for one day's free use when the minimum number of sites are reserved and used. The person may reserve the meeting hall for additional days at the normal rental rate.

(g) Special facilities such as lodges, Silver Falls Youth Camp, Silver Falls Ranches, and other special facilities as designated by the department are not included in the group camping program.

(h) A person must make reservations at least two months prior to arrival date to qualify for group camping benefits.

(9) When only a portion of a specific type of facility in a park is designated as ADA compliant, the department will hold the facility designated as ADA compliant for use by individuals with disabilities until all other facilities of that type have been reserved and the accessible facility is the only remaining facility of that type available in the park.

Stat. Auth.: ORS 390.124

Stats. Implemented: ORS 390.111, 390.121 & 390.124

Hist.: 1 OTC 56(Temp), f. & ef. 4-4-75; 1 OTC 59, f. 8-1-75, ef. 8-25-75; 1 OTC 74, f. & ef. 4-30-76; 1 OTC 82, f. 5-11-77, ef. 5-14-77; 1 OTC 5-1979, f. & ef. 2-9-79; 1 OTC 22-1979(Temp), f. & ef. 9-9-24-79; 1 OTC 2-1980, f. & ef. 1-4-80; PR 9-1981, f. & ef. 4-6-81; PR 2-1994, f. & cert. ef. 2-9-94; PR 2-1995, f. & cert. ef. 1-23-95; PR 3-1996, f. & cert. ef. 5-13-96; PRD 10-2003, f. & cert. ef. 10-17-03; PRD 8-2004, f. & cert. ef. 6-3-04; Renumbered from 736-010-0099, PRD 4-2005, f. & cert. ef. 5-5-05; PRD 7-2009, f. 6-2-09, cert. ef. 8-1-09; PRD 15-2009, f. & cert. ef. 9-29-09; PRD 5-2010, f. & cert. ef. 3-24-10; PRD 5-2011, f. & cert. ef. 8-1-11; PRD 9-2012, f. & cert. ef. 11-16-12; PRD 1-2015, f. & cert. ef. 9-28-15; PRD 3-2016, f. & cert. ef. 7-13-16

736-015-0026
Group Day Use

(1) At designated park areas, a person may reserve a group picnic area(s) by calling the Oregon State Parks Reservation Center during normal business hours. The park manager will determine the maximum group size for each park facility.

(2) The department will charge group picnic rental rates to offset additional park administration and maintenance costs:

(a) Base rate (0–50 people) — $50;

(b) Charges for persons in excess of the 50 person base rate will be $1 per person

(3) The park manager may make advance arrangements with the group leader for parking, supervision, cleanup, checkout time, and other pertinent details.

(4) Upon arrival, the group leader will check in with the park manager who will direct the group to the reserved area.

(5) The group must have adult supervision at all times.

(6) Pursuant to ORS 105.672 to 105.696, group day use rental charges under this rule are for use of the assigned area or park facility of the state park land for picnicking and not for any other recreational purpose or area of state park land. The immunities provided under ORS 105.682 apply to use of state park land for any other recreational purpose.

Stat. Auth.: ORS 390.124

Stats. Implemented: ORS 390.111, 390.121, 390.124 & HB 3673 (2010)

Hist.: 1 OTC 17, f. 12-20-73; 1 OTC 23, f. 2-19-74; 1 OTC 56 (Temp), f. & ef. 4-4-75; 1 OTC 59, f. 8-1-75, ef. 8-25-75; 1 OTC 74, f. & ef. 4-30-76; 1 OTC 83(Temp), f. 5-19-77, ef. 6-1-77; 1 OTC 85, f. & ef. 7-20-77; 1 OTC 3-1979, f. & ef. 2-9-79; 1 OTC 2-1980, f. & ef. 1-4-80; PR 9-1981, f. & ef. 4-6-81; PR 1-1988, f. & cert. ef. 3-25-88; PR 1-1992, f. & cert. ef. 2-14-92; PR 3-1996, f. & cert. ef. 5-13-96; PRD 8-2004, f. & cert. ef. 6-3-04; Renumbered from 736-010-0115, PRD 4-2005, f. & cert. ef. 5-5-05; PRD 15-2009, f. & cert. ef. 9-29-09; PRD 6-2010(Temp), f. & cert. ef. 4-15-10 thru 10-8-10; Administrative correction 10-26-10; PRD 7-2011, f. & cert. ef. 11-28-11; PRD 4-2013, f. & cert. ef. 10-1-13; PRD 3-2016, f. & cert. ef. 7-13-16

736-015-0035
Fee Waivers and Refunds

(1) The director, at the direction of the commission, may waive, reduce or exempt fees established in this division under the following conditions:

(a) A person or group provides in-kind services or materials equal to or greater than the value of the applicable rate, as determined by criteria approved by the director;

(b) Marketing or promotional considerations, including but not limited to special events and commercial filming, that promote the use of park areas and Oregon tourism;

(c) Traditional tribal activities in accordance with policy adopted by the Commission;

(d) Reduced service levels at a park, campsite or other facility as determined by the Park Manager.

(2) Reservation Facility Deposit Fee Waivers for individual primitive, tent, electric, full hook-up or horse camp campsites only:

(a) The facility deposit fee is waived for reservations on State Parks Day (first Saturday of June). All other fees apply.

(b) The facility deposit fee is waived for foster families and adoptive foster families as defined in OAR 736-015-0006. The fee waiver is limited to the first two campsites, and an adult care provider must be present with the foster children. All other fees apply.

(c) The facility deposit fee is waived for U.S. veterans with a service connected disability or active duty U.S. military personnel as provided in ORS 390.124. All other fees apply.

(d) The person making the reservation must pay the $8 non-refundable transaction fee at the time the reservation is made. This fee is not included in the fee waiver.

(3) Overnight Rental Fee Waivers for individual primitive, tent, electric, full hook-up or horse camp campsites only:

(a) The overnight rental fee, including any extra vehicle fees, is waived for all persons on the night of State Parks Day (first Saturday of June). All other fees apply.

(b) The overnight rental fee is waived for foster families and adoptive foster families as defined in OAR 736-015-0006. The fee waiver is limited to the first two campsites, and an adult care provider with one or more foster children must be present. The overnight rental fee waiver is limited to no more than fourteen nights total in a 30-day period. All other fees and rules apply.

(c) The overnight rental fee is waived for U.S. veterans with a service connected disability or active duty U.S. military personnel on leave as provided in ORS 390.124. The overnight rental fee waiver is limited to no more than ten nights total in a 30-day period. The qualifying veteran or active duty military personnel on leave must be present in the site to qualify for the waiver. All other fees and rules apply.

(d) The director may waive the overnight rental fee for volunteer hosts traveling to an assignment at a park area.

(4) Day Use Parking Fee Waivers:

(a) The day use parking fee is waived for all persons on State Parks Day (first Saturday of June).

(b) The day use parking fee is waived for U.S. veterans with a service connected disability or active duty U.S. military personnel on leave as provided in ORS 390.124.

(c) The day use parking fee is waived for foster families and adoptive foster families as defined in OAR 736-015-0006. The waiver shall be valid until the expiration date of the Certificate of Approval to Provide Foster Care or the adopted foster child turns 18 years of age.

(d) All other fees apply.

(5) At those parks offering showers to non-campers, the shower use fee is waived for individuals with an OPRD Special Access Pass.

(6) Proof of Eligibility for Fee Waivers

(a) The department will issue Veterans and Foster families who have provided the department valid proof of eligibility an OPRD Special Access Pass. Pass holders must use the pass to identify themselves as a qualified recipient of fee waivers at state park campgrounds and day use areas. Proof of eligibility must be provided through an application process outlined on the OPRD web site at www.oregonstateparks.org or by calling the OPRD Information Center at 1-800-551-6949 for instructions.

(b) The department will accept the following forms of proof to qualify for fee waivers as a U.S. veteran with a service connected disability:

(A) Disabled Veteran's license plate issued by the Oregon DMV;

(B) A current Disabled Veteran Permanent Hunting/Angling License issued by the Oregon Department of Fish and Wildlife;

(C) A Washington State Parks Disabled Veteran's ID card;

(D) A United States Department of Veterans Affairs (VA) photo identification card bearing the words "service connected";

(E) A letter issued by the VA stating eligibility for any of the above programs, or bearing the words "service-connected disability."

(c) The department will accept the following forms of proof to qualify for fee waivers as an adoptive foster family, as defined in OAR 736-015-0006, with an adopted foster child under 18 years of age or a foster family, as defined in OAR 736-015-0006:

(A) Certificate of Approval to Maintain a Foster Home for Children with Developmental Disabilities;

(B) Certificate of Approval to Maintain a Foster Home for Children;

(C) Certificate of Approval to Maintain a Relative Home for Children;

(D) Written certification from Department of Human Services identifying the applicant as an adoptive or guardian foster family.

(d) The department will not issue an Active Duty Military on official leave a Special Access Pass. Such customers must pay any applicable fee and after their visit may request a refund by sending a letter from their commanding officer on official letterhead stating they were on leave for the dates they camped and their camping receipt to the Oregon State Parks Reservation Center within 30 days after departure date of the stay. A refund of applicable fees will be sent within three weeks of the receipt of their valid request.

(7) There will be no charge for issuing a Special Access Pass or renewing an expired pass. There will be a processing fee of $5.00 for replacement of a lost pass that is still valid.

(8) The department may revoke or temporarily suspend an OPRD Special Access Pass issued under section (6) if:

(a) The pass is used to waive fees beyond the allowable limits in a 30-day period;

(b) The pass holder does not occupy a site when fees have been waived under authority of their pass; or

(c) The pass holder transfers their pass to another person to use.

(9) Pass holders must cancel their reservation three days prior to arrival to avoid a penalty. Cancellations within the three day period will be charged a penalty equal to one nights facility fee for the type of site reserved.

(10) Pass holders who make a reservation and do not check in at the park or notify park staff that they will be delayed, prior to 1:00 p.m. of the second day of the reservation, will be considered a "no show" and the entire reservation will be cancelled. A penalty equal to one overnight rental fee for the type of site reserved will be charged.

(11) If a pass holder vacates their site one or more days prior to check-out without notifying park staff, any days remaining on the reservation will be counted against their monthly waiver limit.

(12) A person may request a refund under the following circumstances.

(a) The Oregon State Parks Reservation Center may refund a reservation fee when the department has made a reservation error.

(b) The Oregon State Parks Reservation Center may refund a facility deposit and may waive the cancellation or change rules when requested by the person due to the following emergency situations:

(A) Emergency vehicle repair creates a late arrival or complete reservation cancellation;

(B) A medical emergency or death of a family member creates a late arrival or complete reservation cancellation;

(C) Acts of Nature create dangerous travel conditions; or

(D) Deployment of military or emergency service personnel creates a late arrival or complete reservation cancellation.

(c) The director or his/her designee may approve a refund under other special circumstances.

(d) All requests for refunds under this section must be sent in writing to the Oregon State Parks Reservation Center via email, fax or surface mail to be considered for a refund.

(e) The department will issue refunds for specific site or park area closures and no written request is required.

(f) The park manager may only issue a refund at the park due to the person leaving earlier than expected, and while the person is present and has signed for the refund. Once the person has left the park, refund requests must be sent to the Oregon State Parks Reservation Center for processing.

Stat. Auth.: ORS 390.124

Stats. Implemented: ORS 390.111, 390.121 & 390.124

Hist.: 1 OTC 17, f. 12-20-73; 1 OTC 56(Temp), f. & ef. 4-4-75; 1 OTC 59, f. 8-1-75, ef. 8-25-75; 1 OTC 74, f. & ef. 4-30-76; 1 OTC 82, f. 5-11-77, ef. 5-14-77; 1 OTC 5-1979, f. & ef. 2-9-79; 1 OTC 22-1979 (Temp), f. & ef. 9-24-79; 1 OTC 2-1980, f. & ef. 1-4-80; PR 9-1981, f. & ef. 4-6-81; PR 11-1986, f. & ef. 7-9-86; PR 1-1988, f. & cert. ef. 3-25-88; PR 1-1990, f. & cert. ef. 5-14-90; PR 4-1991, f. 4-30-91, cert. ef. 5-13-91; PR 3-1996, f. & cert. ef. 5-13-96; PRD 7-2002, f. & cert. ef. 7-1-02; PRD 6-2003, f. 10-3-03 cert. ef. 11-1-03; PRD 8-2004, f. & cert. ef. 6-3-04; Renumbered from 736-010-0120, PRD 4-2005, f. & cert. ef. 5-5-05; PRD 5-2005(Temp), f. 10-14-05, cert. ef. 11-11-05 thru 4-30-06; PRD 1-2006, f. & cert. ef. 2-14-06; PRD 8-2009, f. & cert. ef. 6-2-09; PRD 15-2009, f. & cert. ef. 9-29-09; PRD 1-2010, f. & cert. ef. 1-5-10; PRD 5-2011, f. & cert. ef. 8-1-11; PRD 4-2013, f. & cert. ef. 10-1-13; PRD 1-2016, f. & cert. ef. 3-16-16; PRD 4-2013, f. & cert. ef. 10-1-13; PRD 3-2016, f. & cert. ef. 7-13-16

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Secretary of State, Elections Division
Chapter 165

Rule Caption: Adopts revisions to Elections Division procedural manuals

Adm. Order No.: ELECT 2-2016

Filed with Sec. of State: 7-6-2016

Certified to be Effective: 7-6-16

Notice Publication Date: 6-1-2016

Rules Amended: 165-010-0005, 165-012-0005, 165-014-0005, 165-016-0000

Rules Repealed: 165-014-0280

Subject: A. 165-010-0005

Proposed amendment adopts January 2016 revision of the:

(1) State Candidate's Manual as the procedures and forms to be used by candidates filing and running for federal or state office as that term is defined in ORS 249.002(10);

(2) County, City and District Candidate's Manual as the procedures and forms to be used by candidates filing and running for elected office in a county, city or district; and

(3) Political Party Manual as the procedures and forms to be used to form a minor political party and nominate candidates for elective office. This manual also includes information on qualifying as a major political party and a party's obligation to file organizational documents.

B. 165-012-0005

Proposed amendment adopts January 2016 revision of the 2016 Campaign Finance Manual and associated forms as the procedures and guidelines to be used for compliance with Oregon campaign finance regulations.

C. 165-014-0005

Proposed amendment adopts January 2016 revision of the:

(1) State Initiative and Referendum Manual as the procedures and forms to be used for the state initiative and referendum process;

(2) County, City and District Initiative and Referendum Manual as the procedures, except where state law permits the procedure to be otherwise under local charter or ordinance, and forms to be used for the local initiative and referendum process;

(3) Circulator Training Manual as the curriculum, procedures and forms to be used to register as required under ORS 250.048 by a person who will be paid to gather signatures on a state prospective initiative, initiative, referendum or recall petition;

(4) Recall Manual as the procedures and forms to be used for the recall process; and

(5) County, City and District Referral Manual as the procedures, except where state law permits the procedure to be otherwise under local charter or ordinance, and forms to be used for the local referral process.

C. 165-014-0280

Rule proposed for repeal as the Circulator Training and Registration Manual 2016 revisions are proposed for adoption under OAR 165-014 -0005.

D. 165-016-0000

Proposed amendment adopts January 2016 revision of the Voters' Pamphlet Manual and associated forms as the procedures by which statements, photos, or arguments must be filed as well as the order in which they will appear in the state voters' pamphlet, allowable

formatting and provides a process for contacting statement or argument filers regarding required revisions.

Rules Coordinator: Brenda Bayes—(503) 986-1518

165-010-0005

Designating the Candidate's Manual, Minor Political Party Manual and Forms

(1) The Secretary of State designates the *State Candidate's Manual* revised 01/2016 and associated forms as the procedures and forms to be used by candidates filing and running for a federal or state office as that term is defined in ORS 249.002(10).

(2) The Secretary of State designates the *County, City and District Candidate's Manual* and associated forms as the procedures and forms to be used by candidates filing and running for elected office in a county, city or district.

(3) The Secretary of State designates the *Political Party Manual* revised 01/2016 and associated forms as the procedures and forms to be used to form a minor political party and nominate candidates for elective office. This manual also includes information on qualifying as a major political party and a party's obligation to file organizational documents.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 246.120, 246.150 & 249.009

Stats. Implemented: ORS 246.120, 246.150 & 249.009

Hist.: SD 35-1980, f. & ef. 3-6-80; SD 31-1983, f. & ef. 12-20-83; SD 5-1986, f. & ef. 2-26-86; ELECT 9-1992(Temp), f. & cert. ef. 4-9-92; ELECT 32-1992, f. & cert. ef. 10-8-92; ELECT 33-1993, f. & cert. ef. 11-1-93; ELECT 1-1996, f. & cert. ef. 1-3-96; ELECT 8-1997, f. & cert. ef. 10-3-97; ELECT 3-1998, f. & cert. ef. 2-11-98; ELECT 6-1998, f. & cert. ef. 5-8-98; ELECT 10-1999, f. & cert. ef. 10-18-99; ELECT 3-2002, f. & cert. ef. 3-13-02; ELECT 18-2003, f. & cert. ef. 12-5-03; ELECT 2-2004(Temp), f. & cert. ef. 4-9-04 thru 10-6-04; Administrative correction 10-22-04; ELECT 9-2005, f. & cert. ef. 12-14-05; ELECT 11-2007, f. & cert. ef. 12-31-07; ELECT 25-2009, f. & cert. ef. 12-31-09; ELECT 1-2011, f. & cert. ef. 2-4-11; ELECT 16-2011(Temp), f. & cert. ef. 8-16-11 thru 12-31-11; ELECT 4-2012, f. & cert. ef. 1-3-12; ELECT 6-2014, f. & cert. ef. 1-2-14; ELECT 11-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 2-2016, f. & cert. ef. 7-6-16

165-012-0005

Designating the Campaign Finance Manual and Forms; Late Penalty Matrix

Pursuant to ORS 260.156, the Secretary of State designates the *2016 Campaign Finance Manual* and associated forms as the procedures and guidelines to be used for compliance with Oregon campaign finance regulations.

[Publications: Publications and Forms referenced are available from the agency.]

Stat. Auth.: ORS 246.120, 246.150, 260.156 & 260.200

Stats. Implemented: ORS 246.120, 246.150, 260.156 & 260.200

Hist.: SD 101, f. & ef. 12-3-75; SD 120, f. & ef. 12-21-77; SD 34-1980, f. & ef. 3-6-80; SD 28-1983, f. & ef. 12-20-83; SD 3-1986, f. & ef. 2-26-86; ELECT 32-1988(Temp), f. & cert. ef. 8-26-88; ELECT 22-1989(Temp), f. & cert. ef. 11-9-89; ELECT 19-1990, f. & cert. ef. 6-4-90; ELECT 14-1992 (Temp), f. & cert. ef. 6-10-92; ELECT 37-1992, f. & cert. ef. 12-15-92; ELECT 34-1993, f. & cert. ef. 11-1-93; ELECT 1-1995(Temp), f. & cert. ef. 2-23-95; ELECT 15-1995, f. & cert. ef. 12-18-95; ELECT 9-1996, f. & cert. ef. 7-26-96; ELECT 5-1997, f. & cert. ef. 3-24-97; ELECT 6-1997(Temp), f. & cert. ef. 4-18-97; ELECT 15-1997, f. & cert. ef. 12-31-97; ELECT 5-1998, f. & cert. ef. 2-26-98; ELECT 8-1998, f. & cert. ef. 6-2-98; ELECT 9-1998, f. & cert. ef 9-11-98; ELECT 13-1998(Temp), f. & cert. ef. 12-15-98 thru 6-13-99; ELECT 2-1999(Temp), f. & cert. ef. 1-15-99 thru 7-14-99; ELECT 3-1999, f. & cert. ef. 3-1-99; ELECT 1-2000, f. & cert. ef. 1-3-00; ELECT 3-2002, f. & cert. ef. 3-13-02; ELECT 23-2003, f. & cert. ef. 12-12-03; ELECT 13-2005, f. & cert. ef. 12-30-05; ELECT 1-2007, f. & cert. ef. 1-5-07; ELECT 2-2007(Temp), f. & cert. ef. 5-2-07 thru 10-29-07; ELECT 4-2007(Temp), f. & cert. ef. 7-16-07 thru 12-31-07; ELECT 13-2007, f. & cert. ef. 12-31-07; ELECT 8-2009, f. & cert. ef. 5-4-09; ELECT 16-2009, f. & cert. ef. 7-30-09; ELECT 27-2009, f. & cert. ef. 12-31-09; ELECT 3-2010, f. & cert. ef. 4-22-10; ELECT 8-2011, f. & cert. ef. 4-8-11; ELECT 12-2011, f. & cert. ef. 7-12-11; ELECT 21-2011(Temp), f. & cert. ef. 9-30-11 thru 12-30-11; ELECT 5-2012, f. & cert. ef. 1-3-12; ELECT 2-2-14, f. & cert. ef. 1-2-14; ELECT 14-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 2-2016, f. & cert. ef. 7-6-16

165-014-0005

Designating the Initiative, Referendum and Recall Manuals and Forms

(1) The Secretary of State designates the *State Initiative and Referendum Manual* revised 01/2016 and associated forms as the procedures and forms to be used for the state initiative and referendum process.

(2) The Secretary of State designates the *Recall Manual* revised 01/2016 and associated forms as the procedures and forms to be used for the recall process.

(3) The Secretary of State designates the *County, City and District Initiative and Referendum Manual* revised 01/2016 and associated forms as the procedures, except where state law permits the procedure to be otherwise under local charter or ordinance, and forms to be used for the local initiative and referendum process.

(4) The Secretary of State designates the *County, City and District Referral Manual* revised 01/2016 and associated forms as the procedures, except where state law permits the procedure to be otherwise under local charter or ordinance, and forms to be used for the local referral process.

(5) The Secretary of State designates the *Circulator Training and Registration Manual* revised 01/2016 and associated forms as the curriculum, procedures and forms to be used to register as required under ORS 250.048 by a person who will be paid to gather signatures on a state initiative, referendum or recall petition.

(6) For purposes of subsection (5) of this rule, initiative is meant to include each phase of the petition's signature gathering effort including the sponsorship phase, the primary signature gathering effort and any supplemental signature gathering efforts.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 264.120, 246.150 & 250.015

Stats. Implemented: ORS 246.120, 246.150 & 250.015

Hist.: SD 120, f. & ef. 12-21-77; SD 7-1979(Temp), f. & ef. 11-5-79; SD 31-1980, f. & ef. 3-6-80; SD 10-1984, f. & ef. 6-19-84; SD 21-1984(Temp), f. & ef. 10-8-84; SD 4-1986, f. & ef. 2-26-86; ELECT 33-1988(Temp), f. & cert. ef. 8-26-88; ELECT 4-1989(Temp), f. & cert. ef. 8-11-89; ELECT 4-1991 (Temp), f. & cert. ef. 3-18-91; ELECT 10-1992(Temp), f. & cert. ef. 4-9-92; ELECT 19-1992(Temp), f. & cert. ef. 7-1-92; ELECT 39-1992, f. & cert. ef. 12-17-92; ELECT 3-1993 (Temp), f. & cert. ef. 1-22-93; ELECT 10-1993, f. & cert. ef. 3-25-93; ELECT 35-1993, f. & cert. ef. 11-1-93; ELECT 1-1996, f. & cert. ef. 1-3-96; ELECT 8-1997, f. & cert. ef. 10-3-97; ELECT 3-1998, f. & cert. ef. 2-11-98; ELECT 10-1999, f. & cert. ef. 10-18-99; ELECT 3-2002, f. & cert. ef. 3-13-02; Elect 9-2002(Temp), f. & cert. ef. 12-5-02 thru 6-3-03; ELECT 4-2003, f. & cert. ef. 4-25-03; ELECT 20-2003, f. & cert. ef. 12-5-03; ELECT 10-2005, f. & cert. ef. 12-14-05; ELECT 3-2007(Temp), f. & cert. ef. 5-14-07 thru 11-10-07; Administrative correction 11-17-07; ELECT 16-2007, f. & cert. ef. 12-31-07; ELECT 32-2009, f. & cert. ef. 12-31-09; ELECT 7-2012, f. & cert. ef. 1-3-12; ELECT 5-2014, f. & cert. ef. 1-2-14; ELECT 17-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 2-2016, f. & cert. ef. 7-6-16

165-016-0000
Designating the State Voters' Pamphlet Manual and Forms

The Secretary of State designates the *State Voters' Pamphlet Manual*, revised 01/2016 and associated forms as the procedures and forms to be used to submit candidate statements, measure arguments, statements of arguments by any political party or assembly of electors, arguments in support of a legislative referral, explanatory statements, financial estimates and statements, statements prepared by the Legislative Counsel Committee under ORS 251.225 and county or metropolitan service district measures submitted under ORS 251.285.

Stat. Auth.: ORS 246.150, 251.014, 251.065, 251.075, 251.255
Stats. Implemented: ORS 251.046, 251.065, 251.075, 251.085, 251.087 & 251.095, 251.115, 251.255, 251.285
Hist.: ELECT 9-2014, f. & cert. ef. 3-11-14; ELECT 13-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 2-2016, f. & cert. ef. 7-6-16

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Rule Caption: Adopts revisions to specified election law reporting requirements, procedures and enforcement actions
Adm. Order No.: ELECT 3-2016
Filed with Sec. of State: 7-6-2016
Certified to be Effective: 7-6-16
Notice Publication Date: 6-1-2016
Rules Adopted:
Rules Amended: 165-001-0016, 165-001-0025, 165-001-0034, 165-001-0050, 165-001-0095, 165-005-0055, 165-005-0065, 165-005-0070, 165-007-0035, 165-012-0240, 165-013-0010, 165-013-0020, 165-013-0030, 165-014-0100, 165-014-0260
Subject: A. Procedural Rules:

165-001-0016, 165-001-0025, 165-001-0034, 165-001-0050: Proposed amendment updates references to the hearing request form number; incorporates deadlines for issuing a default final order when no hearing is requested, a hearing request is cancelled or a person does not show up at the hearing; and establishes where and when written exceptions to a proposed order must be filed.

165-001-0095: Proposed adoption of requirements for complaints filed with the State Elections Division and establishment of procedures for complaints filed with other elections filing officers.

B. NVRA Agency Registration Procedures and Reporting Requirements:

165-005-0055, 165-005-0065, 165-005-0070: Proposed amendment appropriately identifies designated Voter Registration Agencies after organizational name change; designates CCare as a Voter Registration Agency; removes the requirement for the Secretary of State to print Voter Registration Agency reporting forms and instead allows for the Secretary to designate a print or electronic form that Voter Registration Agencies must use to report the number of registration cards submitted to county elections officials; and fixes a grammatical error.

C. Designating Ballot Request Forms

165-007-0035: Proposed amendment replaces reference to "Federal Absentee Ballot Request Form" with "Federal Post Card Application". "Federal Post Card Application" is the current name for the federal form military and overseas voters must submit to request an absentee ballot.

D. Administrative Discontinuation of a Political Committee:

165-012-0240: Proposed amendment expands the manner in which a person may respond to a Notice of Discontinuation.

E. Election Offenses:

165-013-0010: Proposed amendment adds an alternate transaction filer and independent expenditure filer to mitigating circumstances the Secretary may

consider in reducing or waiving a penalty for Other Campaign Finance Violations.

165-013-0020: Proposed amendment clarifies when an offense is considered to be a single or multiple violations, clarifies the minimum penalty for violations of Article IV, section 1b of the Oregon Constitution, clarifies the minimum penalty for violations of ORS 260.569 and

removes certain mitigating circumstances for violations of ORS 260.432.

165-013-0030: Proposed amendment adopts January 2016 revisions to the Restrictions on Political Campaigning by Public Employees, ORS 260.432 Manual. The manual provides guidance on ORS 260.432 and informs the public of permissible and impermissible activities by public

employees.

F. Initiative and Referendum Prohibitions and Requirements

165-014-0100: Proposed amendment requires chief petitioner accounts for the sponsorship phase of an initiative petition be submitted with the first accounts submittal of the primary signature gathering effort.

165-014-0260: Proposed amendment corrects an incorrect quote of Article IV, Section 1b of the Oregon Constitution and to clarifies the minimum penalty for violations of Article IV, Section 1b of the Oregon Constitution.
Rules Coordinator: Brenda Bayes—(503) 986-1518

165-001-0016
Requesting a Hearing

(1) If a party wishes to request an in-person or telephone hearing to contest the allegations in the charging document, they must submit to the Agency a signed Hearing Request Form and an "answer," to the allegations in the charging document not later than the deadline to request a hearing stated in the charging document.

(a) The answer must include an admission or denial of each factual matter alleged in the charging document and a statement of each relevant defense to the allegations, including any relevant mitigating circumstance that may apply and indicate specifically what facts or transactions the mitigating circumstance applies to.

(b) A general denial is not sufficient to constitute an answer.

(c) The person must choose whether they want the hearing by telephone or in-person. If no choice is indicated on the form, the hearing will be held by telephone.

(d) Any evidence of a mitigating circumstance or other relevant evidence may be submitted with the answer as exhibits.

(2) An answer not including the information required by this rule may be disregarded and a notice of default may be issued in accordance with OAR 165-001-0025 as if no answer had been filed.

(3) Except for good cause shown to the administrative law judge, factual matters alleged in the charging document and not denied in the answer will be deemed admitted by the party.

(4) The failure of the party to raise a mitigating circumstance in the answer is a waiver of such mitigating circumstance.

(5) The party bears the burden of proof to show that all or part of the penalty should be mitigated based on a mitigating circumstance.

(6) Any new facts or defenses alleged in the answer will be deemed denied by the Agency.

(7) Evidence will not be taken at the contested case hearing on any factual or legal issue not raised in the charging document or the answer as filed.

(8) The Secretary of State hereby adopts by reference and designates the SEL 850 as the Hearing Request Form, Campaign Finance Transactions to be used to request an in-person or telephone hearing, or submit notarized testimony to contest campaign finance transaction violations.

(9) The Secretary of State hereby adopts by reference and designates the SEL 851 as the Hearing Request Form, Other Campaign Finance Violations to be used to request an in-person or telephone hearing, or submit notarized testimony to contest campaign finance violations, other than those violations relating to late or insufficient campaign finance transactions.

(10) The Secretary of State hereby adopts by reference and designates the SEL 852 as the Hearing Request Form to be used to request an in-person or telephone hearing to contest non-campaign finance violations.

Stat. Auth.: ORS 246.150
Stats. Implemented: ORS 260.232 & 260.995
Hist.: ELECT 7-2011, f. & cert. ef. 4-8-11; ELECT 1-2012, f. & cert. ef. 1-3-12; ELECT 15-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-001-0025
Orders When No Hearing Requested, Hearing is Cancelled, or Failure to Appear at Hearing

(1) When a party has been given an opportunity to request a hearing and fails to request a hearing in writing within the specified time, or having requested a hearing fails to appear at the specified time and place, the agency shall, subject to section (2) of this rule, enter an order by default which supports the agency action.

(2)The time provided by statute to request a hearing under ORS 260.995 is calculated from the delivery date indicated on the certified letter's postal confirmation. If the certified letter is refused or left unclaimed at the post office, the time shall be calculated from the date the post office indicates it has given first notice of a certified letter. If the certified card is not returned to the Secretary of State by the United States Postal Service (USPS), the Secretary shall use the date recorded on the official USPS website utilizing the Track and Confirm delivery service.

(3) The time provided by statute to request a hearing under ORS 260.232 is 20 calendar days after the service date on the charging document.

(2) An order adverse to a party may be issued on default only if the agency record demonstrates a prima facie case justifying the order. The Administrative Law Judge will declare a party to be in default if the party which requested the hearing does not appear within 15 minutes of the time set for the hearing, unless the party gives notice of a reason for the inability to appear at the designated time and requests and receives a continuance. A continuance shall be granted only if the reason for the inability to appear is beyond the reasonable control of the party.

(3) The prima facie record upon default may be made at a scheduled hearing on the matter, or, if the notice of intended action states that the order will be issued or become effective upon the failure of the party to timely request a hearing, when the order is issued.

(4) The record may consist of oral (transcribed, recorded, or reported) or written evidence or a combination of oral and written evidence. When the record is made at the time the notice or order is issued, the agency file may be designated as the record. In all cases, the record must contain substantial evidence to support the findings of fact.

(5) When the Administrative Law Judge has set a specified time and place for a hearing and the party subsequently notifies the agency or the Administrative Law Judge assigned to the case that the party will not appear at such specified time and place, the agency may cancel the hearing and follow the procedure described in subsections (2), (3) and (4) of this rule.

(6) The deadline to issue a Final Order by Default if there is no hearing request, the hearing is cancelled or the party fails to appear at the hearing is not later than the 90th day after the deadline to request a hearing.

(7) When a party requests a hearing after the time specified by the agency, but before entry of a final order by default, or, if a final order by default is entered, on or before 30 calendar days after entry of the order, the agency may accept the late request only if the cause for failure to timely request the hearing was beyond the reasonable control of the party. In determining whether to accept a late hearing request, the agency may require the request to be supported by an affidavit and may conduct such further inquiry, including holding a hearing, that it deems appropriate. The agency shall enter an order granting or denying the request.

(8) When a party requests a hearing after entry of a default order, the party must file the request within a reasonable time. If the request is received more than 30 days after the agency mailed the default order to the party or the party's attorney (based on the service date of the order), it is presumed that the request is not timely. The request shall state why the party should be relieved of the default order. If the request is allowed by the agency, it shall enter an order granting the request and schedule the hearing in due course. If the request is denied, the agency shall enter an order setting forth its reasons for the denial.

(9) The agency shall notify a defaulting party of the entry of a default order by mailing a copy of the order as required by ORS 183.470.

(10) Notwithstanding the provisions of this rule relating to late requests for a hearing, no hearing may be held if the timing of the request would cause the agency to miss the statutory deadlines established for the conduct of hearings in ORS 260.232(4) or 260.995(6).

Stat. Auth.: ORS 183.090, 183.470, 246.150, 260.232 & 260.995
Stats. Implemented: ORS 183.470, 260.232 & 260.995
Hist.: ELECT 15-1988(Temp), f. & cert. ef. 1-27-88; ELECT 26-1988, f. & cert. ef. 8-1-88; ELECT 27-1993, f. & cert. ef. 7-1-93; ELECT 15-1994, f. & cert. ef. 7-26-94; ELECT 7-2003, f. & cert. ef. 9-3-03; ELECT 19-2009, f. & cert. ef. 12-31-09; ELECT 1-2012, f. & cert. ef. 1-3-12; ELECT 15-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-001-0034
Notarized Testimony in lieu of Hearing

(1) If a party wishes to contest the allegations in the charging document, but does not wish to request an in person or telephone hearing, the party may submit notarized testimony in lieu of a hearing.

(2) The notarized testimony must be filed with the Agency not later than the deadline to request a hearing stated in the charging document.

(3) The notarized testimony must:

(a) Include an admission or denial of each factual matter alleged in the charging document and a statement of each relevant defense to the allegations, including any relevant mitigating circumstance. A general denial is not sufficient. Notarized testimony not including the information required by this rule may be disregarded and a notice of default may be issued in accordance with OAR 165-001-0025 as if no notarized testimony had been filed.

(b) Include a signed and completed Hearing Request Form.

(c) Be notarized by a commissioned Notary Public.

(4) After the party submits notarized testimony, the Agency may submit notarized testimony and any exhibits to the Office of Administrative Hearings and to the individual who submitted notarized testimony. If the Agency submits notarized testimony, it will be transmitted via e-mail to the Office of Administrative Hearings and the party. The Agency may mail its notarized testimony to the party's last known address if the party's e-mail address is unknown or the e-mail is returned as undeliverable.

(5) The party may, but is not required to, respond to the Agency testimony by submitting rebuttal notarized testimony.

(a) Rebuttal notarized testimony is limited to issues raised in the original notarized testimony and the Agency's testimony.

(b) Rebuttal notarized testimony must be notarized by a commissioned Notary Public.

(c) The rebuttal notarized testimony must be received by the Agency not later than five business days from the date of service of the Agency's testimony (the date the testimony was e-mailed or mailed).

(d) The notarized testimony hearing record is deemed closed the day after the deadline for the person to submit rebuttal testimony.

(6) If a person submits notarized testimony in lieu of requesting an in person or telephone hearing, the person is waiving their right to an in person or telephone hearing.

(7) The deadline to issue a final order when notarized testimony is submitted in lieu of an in-person or telephone hearing is not later than 90 days after the hearing record is closed.

Stat. Auth.: ORS 246.150
Stats. Implemented: ORS 260.232 & 260.995
Hist.: ELECT 7-2011, f. & cert. ef. 4-8-11; ELECT 1-2012, f. & cert. ef. 1-3-12; ELECT 15-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-001-0050
Proposed Orders in Contested Cases, Filing of Exceptions, Argument, and Adoption of Order

(1) The administrative law judge shall prepare a proposed order and serve the proposed order on the agency and each party. The proposed order shall be served not later than 30 calendar days after the hearing is adjourned. The proposed order shall also include information about when and where written exceptions to the proposed order must be filed to be considered by the agency.

(2) The exceptions must be received by the Elections Division not later than 30 calendar days after the service date of the proposed order. The date of service is the day the proposed order is mailed, not the date the party receives the proposed order.

(3) If the administrative law judge's proposed order recommended a decision favorable to a party and the agency intends to reject that recommendation and issue an order adverse to that party, the agency shall issue an amended proposed order. When the agency serves an amended proposed order on the party, the agency shall, at the same time notify the party when and where written exceptions for the amended order must be filed to be considered by the agency.

(4) Written exceptions filed under (2) or (3) may be scanned and attached to an email and sent to elec-hearings.sos@state.or.us, transmitted by fax (503-373-7414), mailed or hand-delivered to 255 Capitol St NE, Ste 501, Salem OR 97310.

(5) The agency decision maker, after considering any of the written exceptions may adopt the proposed order, amended proposed order or prepare a new order.

Stat. Auth.: ORS 183.090, 183.470, 246.150, 260.232 & 260.995
Stats. Implemented: ORS 183.470, 260.232 & 260.995
Hist.: ELECT 15-1988(Temp), f. & cert. ef. 1-27-88; ELECT 26-1988, f. & cert. ef. 8-1-88; ELECT 7-2003, f. & cert. ef. 9-3-03; ELECT 19-2009, f. & cert. ef. 12-31-09; ELECT 10-

2011, f. & cert. ef. 7-12-11; ELECT 4-2014, f. & cert. ef. 1-2-14; ELECT 15-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-001-0095
Complaint Requirements

(1) Any complaint filed pursuant to ORS 260.345 must be signed by an elector of the State of Oregon.

(2) A complaint filed pursuant to ORS 260.345 which is filed with an elections filing officer other than the State Elections Division shall be delivered by the filing officer to the State Elections Division within one business day.

(3) The complaint may be delivered by electronic mail to elections.sos@state.or.us, by facsimile to 503-373-7414 or by mail or personal delivery to 255 Capitol Street NE, Suite 501, Salem, OR 97310.

Stat. Auth.: ORS 246.150, 260.345
Stats. Implemented: ORS 246.232, 260.345, 260.995
Hist.: ELECT 15-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-005-0055
Designating NVRA Voter Registration Agencies

(1) "Voter Registration Agency" means one of the following:

(a) Armed Forces recruitment offices operated by the U.S. Department of Defense;

(b) Commission for the Blind;

(c) Department of Human Services, Aging and People with Disabilities (APD);

(d) Department of Human Services, Child Welfare;

(e) Department of Human Services, Self Sufficiency;

(f) Oregon Health Authority, CCare Program;

(g) Oregon Health Authority, Health Systems Division;

(h) Oregon Health Authority, Women, Infants and Children Nutrition Program (WIC);

(i) Office of Vocational Rehab Services;

(j) Oregon Department of Transportation;

(k) Public universities, as defined in ORS 352.002

(2) "Agency Site" means any voter registration location named by a voter registration agency designated in section (1) of this rule.

(3) "County Elections Official" means the official responsible for voter registration in any county.

(4) Some voter registration agencies are not required under the National Voter Registration Act to be designated as voter registration agencies. Because their status as Voter Registration Agencies is voluntary, public universities are exempt from the requirements of ORS 247.208(2) and (4).

(5) The Armed Forces recruitment offices, operated by the U.S. Department of Defense, are exempt from reporting statistical information to the Secretary of State and report directly to the Election Assistance Commission.

Stat. Auth.: ORS 246.150 & 247.208
Stats. Implemented: ORS 247.208
Hist.: ELECT 10-1991(Temp), f. & cert. ef. 9-27-91; ELECT 18-1992, f. & cert. ef. 7-1-92; ELECT 25-1994, f. & cert. ef. 10-27-94; ELECT 20-2000, f. & cert. ef. 12-8-00; ELECT 8-2003, f. & cert. ef. 9-3-03; ELECT 11-2011, f. & cert. ef. 7-12-11; ELECT 12-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-005-0065
Compiling and Reporting Registrations

(1) The Secretary of State shall provide to Voter Registration Agencies a print or electronic form to use to report the number of voter registration cards sent to the County Elections Official.

(2) At least monthly, on the form or in the manner provided by the Secretary of State, each agency site shall report to the Secretary of State the number of voter registration cards sent to the county elections office since the last report.

(3) County Elections Officials shall record the following voter registration information in the Oregon Centralized Voter Registration System (OCVR) allowing the Secretary of State to compile the information and report to the Election Assistance Commission:

(a) The number of voters registered "active" and the number of voters registered "inactive" at the close of the previous general election;

(b) The number of registrations cancelled between the two most recent federal general elections;

(c) The number of confirmation notices mailed out between the two most recent federal general elections and the number of responses to these notices received during that same period;

(d) The number of valid registrations for people not previously registered to vote in Oregon or who is currently cancelled (New);

(e) The number of registration applications that update an existing registration including the residential address from one county to another (Update); and

(f) The number of registration applications submitted by persons already registered to vote at the same address, under the same name, with the same personal information and the same political party (Duplicate).

(4) New, updated or duplicate registrations shall be recorded in the following categories:

(a) By mail all cards received from individuals that arrive by United States Postal Service;

(b) By other means all cards received from individuals arriving in person or another method, other than by United States Postal Service;

(c) From the Department of Transportation (DMV) — all cards received from DMV offices regardless of how the cards arrive;

(d) From a #3 — agency all cards received from a #3 agency regardless of how the cards arrive. #3 agencies include Addictions and Mental Health Division, Children, Adults & Families Division; and the Office of Family Health Services — WIC;

(e) From a #4 — agency all cards received from a #4 agency regardless of how the cards arrive. #4 agencies include the Commission for the Blind; Seniors & People with Disabilities; and the Office of Vocational Rehab Services;

(f) From Armed Forces Recruitment offices — all cards received from Armed Forces offices regardless of how the cards arrive;

(g) From all other designated voter registration agencies — all cards received from the Oregon University System, Secretary of State or other County Elections Office regardless of how the cards arrive; and

(h) Received on a Federal Voting Assistance Program (FVAP) registration application regardless of how the cards arrive.

Stat. Auth.: ORS 246.150, 247.012 & 247.208
Stats. Implemented: ORS 247.208
Hist.: ELECT 10-1991(Temp), f. & cert. ef. 9-27-91; ELECT 18-1992, f. & cert. ef. 7-1-92; ELECT 25-1994, f. & cert. ef. 10-27-94; ELECT 22-2000, f. & cert. ef. 12-8-00; ELECT 11-2011, f. & cert. ef. 7-12-11; ELECT 12-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-005-0070
Agency Registration Procedures

(1) Personnel at agency sites shall stamp or write on the reverse side of the voter registration card, below the postage area, the date the card is received by voter registration agency personnel.

(2) Voter registration agencies shall provide written notice to the Secretary of State of any change, to the following information within 30 days of the change:

(a) The identity of the NVRA coordinator for the voter registration agency;

(b) The location of each agency site that will offer voter registration; and

(c) The nature of voter registration procedures within the voter registration agency.

(3) Voter registration agency personnel shall not influence or attempt to influence a person to choose or not choose a particular political party or preference, or to register or to vote in any particular manner. Items which personnel shall not wear or display in the presence of clients while offering the opportunity to register to vote include materials that:

(a) Identify past, present, or future holders or seekers of partisan elective office;

(b) Contain logos or other graphics that may be identified with a political party or other party preference;

(c) Would reasonably be understood to be associated with a political party or other political party preference; or

(d) Would reasonably be understood to be advocating support or opposition to a ballot measure or candidate for elective office.

Stat. Auth.: ORS 246.150 & 247.208
Stats. Implemented: ORS 247.208
Hist.: ELECT 4-1992(Temp), f. & cert. ef. 2-26-92; ELECT 18-1992, f. & cert. ef. 7-1-92; ELECT 25-1994, f. & cert. ef. 10-27-94; ELECT 15-2001, f. & cert. ef. 6-15-01; ELECT 8-2003, f. & cert. ef. 9-3-03; ELECT 12-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-007-0035
Designating Ballot Request Forms

(1) The Secretary of State designates form SEL 111, Absentee Ballot Request Form, as the form an elector who will be away during an election, may submit to a county elections official to request an absentee ballot, except that if the elector is serving in the Armed Forces, the Merchant Marine or is temporarily living outside the territorial limits of the United States, the elector must submit a Federal Post Card Application.

(2) The Secretary of State designates form SEL 111A, Absentee Ballot Request Form, as the form an elector who is 17 years old who will be away during an election may submit to a county elections official to request an absentee ballot, except that if the elector is serving in the Armed Forces, the Merchant Marine or is temporarily living outside the territorial limits of the United States, the elector must submit a Federal Post Card Application. The elector will not receive a ballot until an election occurs on or after their eighteenth birthday.

(3) The Secretary of State designates form SEL 113, Provisional Ballot Request Form, as the form an individual whose eligibility as a voter is in question may use to request a ballot. The provisional ballot will not be counted until the individual's eligibility is determined.

Stat. Auth.: ORS 246.150, 254.465, 254.470, Help America Vote Act P.L. 107-252
Stats. Implemented: ORS 247, 253.03 & 254
Hist.: ELECT 5-2006, f. & cert. ef. 4-18-06; ELECT 22-2009, f. & cert. ef. 12-31-09; ELECT 10-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-012-0240
Administrative Discontinuation of a Political Committee

(1) The Elections Division may administratively discontinue a political or petition committee when:

(a) The committee has not filed any transactions under ORS 260.057 for one calendar year; and

(b) The committee's ending cash balance reflected in ORESTAR is not more than $3500.

(2) Not later than 30 days before administratively discontinuing a committee under this section, the Elections Division shall attempt to inform the committee of the proposed discontinuation.

(a) For a candidate committee:

(A) By first class mail sent to the mailing address reported on the most recent Statement of Organization for the candidate and by first class mail to the most recent mailing address for the candidate reported in the Oregon Centralized Voter Registration System. If both addresses are the same, only one letter shall be sent; and

(B) By first class mail to the mailing address reported on the most recent Statement of Organization for the treasurer, if applicable.

(b) For a political committee notice will be sent by first class mail sent to the mailing address reported on the most recent Statement of Organization for the treasurer and by first class mail to the most recent mailing address for the treasurer reported in the Oregon Centralized Voter Registration System. If both addresses are the same, only one letter shall be sent.

(c) For a petition committee:

(A) By first class mail sent to the mailing address reported on the most recent Statement of Organization for the chief petitioner(s) and by first class mail to the most recent address for the chief petitioner(s) in the Oregon Centralized Voter Registration System. If both addresses are the same, only one letter shall be sent; and

(B) By first class mail to the mailing address reported on the most recent Statement of Organization for the treasurer, if applicable.

(3) The notice shall inform the committee that it will be discontinued by the Elections Division unless the committee notifies the Elections Division of reasons why the committee does not meet the criteria of this rule for administrative discontinuation; notification from the committee must be received not later than 20 days after the service date of the letter. "Notification" means contact in writing, via mail, email, fax transmission, or making contact with the Elections Division by phone. The written notice from the Elections Division shall also include:

(a) Notification that the statement of organization will be administratively discontinued 30 days from the date of the letter; and

(b) The applicable reasons for discontinuation listed in subsection (1) of this section.

Stat. Auth.: ORS 246.150, 260.046
Stats. Implemented: ORS 260.046
Hist.: ELECT 14-2005, f. & cert. ef. 12-30-05; ELECT 6-2007, f. & cert. ef. 8-27-07; ELECT 29-2009, f. & cert. ef. 12-31-09; ELECT 5-2012, f. & cert. ef. 1-3-12; ELECT 2-2-14, f. & cert. ef. 1-2-14; ELECT 14-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-013-0010
Penalty Matrix for Other Campaign Finance Violations

(1) This penalty matrix applies to civil penalties for campaign finance violations not covered by the penalty matrices in the Campaign Finance Manual.

(2) Mitigating Circumstances. The only mitigating circumstances that will be considered in a campaign finance violation covered by this rule include:

(a) The violation is a direct result of a valid personal emergency of the candidate, treasurer, alternate transaction filer, or independent expenditure filer. A valid personal emergency is an emergency, such as a serious personal illness or death in the immediate family of the candidate or treasurer which caused the violation to occur. A valid personal emergency does not include a common cold or flu, or a long-term illness where other arrangements could have been made. In this case, independent written verification must be provided;

(b) The violation is the direct result of an error by the elections filing officer;

(c) The violation is the direct result of clearly-established fraud, embezzlement, or other criminal activity against the committee, committee treasurer, candidate, alternate transaction filer, or independent expenditure filer, as determined in a criminal or civil action in a court of law or independently corroborated by a report of a law enforcement agency or insurer or the sworn testimony or affidavit of an accountant or bookkeeper or the person who actually engaged in the criminal activity. This mitigating circumstance is not available to the committee treasurer, candidate, alternate transaction filer, or independent expenditure filer who was the perpetrator of the wrongdoing described above;

(d) The violation is the direct result of fire, flood, utility failure or other calamitous event, resulting in physical destruction of, or inaccessibility to, campaign finance records. ("Calamitous event" means a phenomenon of an exceptional character, the effects of which could not have been reasonably prevented or avoided by the exercise of due care or foresight);

(e) The violation is the direct result of failure of a professional delivery service to deliver documents in the time guaranteed for delivery by written receipt of the service provider. This does not include delivery by fax.

(3)(a) Penalty Matrix. These mitigating circumstances may be considered in reducing, in whole or in part, the civil penalty. If the violation is a direct result of an error by the elections filing officer, the violation is waived and no penalty is assessed.

(b) Omitted or insufficient information for a violation of ORS 260.039(4), 260.042(4) or 260.118(3) submitted prior to the deadline for a candidate or treasurer to request a hearing will result in a 50% reduction of the penalty. If a public hearing is requested, the omitted or insufficient information may be submitted up to the date of the hearing. In such an event, the treasurer, candidate, alternate transaction filer or independent expenditure filer will be entitled to a 50% reduction of the assessed penalty.

(c) For the purpose of issuing a proposed penalty notice and subsequent imposition of a civil penalty for any violation in Appendix A of this rule, the candidate of a principal campaign committee, the treasurer of a political action committee, or the chief petitioner of a petition committee, is the party named in a proposed penalty notice and is the party responsible for the payment of any civil penalty if a penalty is assessed.

(d) For purposes of determining penalty amounts for violations of campaign finance violations covered by this rule Appendix A of this rule will apply.

[ED. NOTE: Appendix referenced is available from the agency.]
Stat. Auth.: ORS 246.150, 260.200
Stats. Implemented: ORS 260.200, 260.215, 260.232, 260.995
Hist.: ELECT 13-2000, f. 7-31-00, cert. ef. 8-4-00; ELECT 22-2003, f. & cert. ef. 12-5-03; ELECT 1-2004, f. & cert. ef. 2-13-04; ELECT 16-2005, f. & cert. ef. 12-30-05; ELECT 10-2006(Temp), f. & cert. ef. 7-6-06 thru 1-2-07; ELECT 17-2006, f. & cert. ef. 12-29-06; ELECT 14-2007, f. & cert. ef. 12-31-07; ELECT 30-2009, f. & cert. ef. 12-31-09; ELECT 9-2011, f. & cert. ef. 4-8-11; ELECT 6-2012, f. & cert. ef. 1-3-12; ELECT 1-2013, f. & cert. ef. 2-4-13; ELECT 1-2014, f. & cert. ef. 1-2-14; ELECT 19-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-013-0020
Penalty Matrix for Non-Campaign Finance Civil Penalty Election Law Violations

(1)(a) This penalty matrix applies to civil penalties for violations of election laws that are not covered by the penalty matrices in the Campaign Finance Manual (late and insufficient campaign finance reports and new transactions to campaign finance reports), or other campaign finance violations as outlined in 165-013-0010.

(b) The penalty amount will be calculated against the same person, candidate or entity as described below for a period of four years from the date the violation occurs, for any election law violation, other than campaign finance violations covered in the penalty matrices in the Campaign Finance Manual and other campaign finance violations as outlined in 165-013-0010.

(c) In determining whether the offense is to be considered against the same person, candidate or entity, the following factors are to be considered:

(A) A person is considered the same candidate, regardless of the office(s) for which the person runs within this state, or whether there is a lapse in time between candidacies.

(B) A political committee is considered the same, regardless of who the treasurer is, or if the political committee has changed names but is established by the same group of persons.

(C) The same individual.

(d) When determining whether the offense is to be considered a single or multiple violations, the following factors are to be considered:

(A) One occurrence is considered one violation.

(B) Violations of Article IV, Section 1(b) will be calculated by deeming each individual signature sheet that contains signatures that were collected in violation of Section 1(b) as a single occurrence.

(C) Violations of ORS 260.569 will be calculated by deeming each individual signature sheet that contains a signature a violation of ORS 260.569 or each signed voter registration card in violation of ORS 260.569 as a single occurrence.

(2) Mitigating Circumstances: The burden is on the person alleged to have committed the election law violation to show that a mitigating circumstance exists and caused the election law violation. The only mitigating circumstances which will be considered, if applicable to the specific situation, include:

(a) The violation is a direct result of a valid personal emergency of the involved person(s). A valid personal emergency is an emergency such as a serious personal illness or death in the immediate family of the involved person(s). Personal emergency does not include a common cold or flu, or a long-term illness where other arrangements could have been made. In this case, independent written verification must be provided;

(b) The violation is the direct result of an error by an elections officer;

(c) The violation is the direct result of fire, flood or other calamitous event, resulting in physical destruction of, or inaccessibility to, any records required to be kept to document compliance with Oregon election law. ("Calamitous event" means a phenomenon of an exceptional character, the effects of which could not have been reasonably prevented or avoided by the exercise of due care or foresight);

(3)(a) Penalty Matrix. These mitigating circumstances may be considered in reducing, in whole or in part, the civil penalty. If the violation is a direct result of an error by an elections officer, the violation is waived and no penalty is assessed.

(b) For purposes of determining penalty amounts for violations of non-campaign finance civil penalty election law violations, Appendix B of this rule will apply.

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

Stat. Auth.: ORS 246.150

Stats. Implemented: ORS 260.995

Hist.: ELECT 14-2000, f. 7-31-00, cert. ef. 8-4-00; ELECT 22-2003, f. & cert. ef. 12-5-03; ELECT 16-2005, f. & cert. ef. 12-30-05; ELECT 15-2007, f. cert ef. 12-31-07; ELECT 9-2009, f. & cert. ef. 5-4-09; ELECT 31-2009, f. & cert. ef. 12-31-09; ELECT 6-2012, f. & cert. ef. 1-3-12; ELECT 19-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-013-0030

Designating Restrictions on Political Campaigning by Public Employees

In addition to, and not in lieu of, any other election processes contained in ORS Chapters 246 through 260 and OAR Chapter 165, the Secretary of State adopts the manual *Restrictions on Political Campaigning by Public Employees*, ORS 260.432 revised 01/2016. This manual provides guidance on ORS 260.432 and informs the public of permissible and impermissible activities by public employees.

Stat. Auth.: ORS 246.150

Stats. Implemented: ORS 260.432

Hist.: ELECT 12-2012, f. & cert. ef. 9-13-12; ELECT 18-2015, f. 12-31-15, cert. ef. 1-2-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-014-0100

Review of Specified Chief Petitioner Accounts

(1) Each chief petitioner of an initiative, referendum or prospective petition who pays any person money or other valuable consideration to obtain signatures on the petition shall keep detailed accounts in accordance with ORS 260.262. The Elections Division will review these accounts in the manner and in accordance with the schedule set out in paragraphs (2) and (3) of this rule.

(2) Chief petitioners shall submit digital copies of the applicable accounts described on the SEL 320 unless they receive prior written approval from the Elections Division to submit paper copies.

(a) Acceptable digital formats include pdf files, Excel files, or Word files submitted on CD-ROM or via electronic mail.

(b) The Elections Division may request original documentation of chief petitioner accounts, in addition to or in lieu of copies.

(c) The Elections Division may choose to conduct on-site reviews of chief petitioner accounts.

(3) Detailed copies of the applicable accounts described on the SEL 320, must be submitted by the 10th business day of each month after any month in which circulators were paid to collect signatures for the primary signature gathering effort. Accounts for the sponsorship phase must be included with the first submittal of accounts for the primary signature gathering effort. The Elections Division may require accounts to be submitted in shortened time frame depending on the circumstances of each petition.

(4) The Elections Division reserves the right to demand all accounts described under ORS 260.262, including all circulated signature sheets.

(5) Chief petitioners, or their authorized agent, must submit a completed SEL 320, each time accounts are provided, detailing the nature of the accounts provided under ORS 260.262.

(6) The Elections Division shall review accounts to determine whether all of the required information appears to have been provided. If after review it is determined that the accounts submitted are incomplete or the chief petitioners fail to submit the requested accounts, the Elections Division may find that a violation of section 1b, Article IV of the Oregon Constitution, has occurred, suspend the petition from obtaining additional signatures, and/or issue a civil penalty under OAR 165-013-0020.

(7) If the Elections Division takes action under ORS 260.262(6) the chief petitioners may file notarized written explanation contesting the suspension and providing evidence that the accounts submitted are complete.

(8) If a petition is suspended under ORS 260.262(6) the chief petitioners are prohibited from obtaining any additional signatures on the petition until it has been determined by the Elections Division that the accounts are complete. Any signatures gathered in violation of the suspension will not be accepted for signature verification.

(9) If the petition has multiple chief petitioners, only one set of copies of the detailed accounts for each petition need to be produced by the deadline.

(10) Accounts must be kept current as of not later than the 7th calendar day after the date a payment is made to a person for obtaining signatures on a petition.

(11) The Elections Division reserves the right to conduct a review of all chief petitioner accounts in accordance with ORS 260.262(4).

Stat. Auth.: ORS 246.150, 260.262

Stats. Implemented: ORS 260.262

Hist.: ELECT 21-2007, f. & cert. ef. 12-31-07; ELECT 3-2008(Temp), f. & cert. ef. 3-14-08 thru 5-2-08; ELECT 6-2008(Temp), f. & cert. ef. 5-2-08 thru 9-10-08; ELECT 8-2008, f. & cert. ef. 8-12-08; ELECT 33-2009, f. & cert. ef. 12-31-09; ELECT 13-2011, f.. & cert. ef. 8-1-11; ELECT 6-2013, f. & cert. ef. 11-8-13; ELECT 16-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

165-014-0260

Prohibition on Paying or Receipt of Payment based on the Number of Signatures Obtained on an Initiative, Referendum, Candidate Nominating Petition or Voter Registration Cards

(1) The purpose of this rule is to interpret Article IV, section 1b of the Oregon Constitution and ORS 260.569. Article IV, section 1b of the Oregon Constitution provides: "It shall be unlawful to pay or receive money or other thing of value based on the number of signatures obtained on an initiative or referendum petition. Nothing herein prohibits payment for signature gathering which is not based, either directly or indirectly, on the number of signatures obtained." ORS 260.569 provides: "A person may not pay or receive money or another thing of value based on the number of: signatures a person obtains for purposes of nominating a candidate for elective public office or signed voter registration cards a person collects.

(2) Section 1b and ORS 260.569 bans the practice of paying circulators or others involved in an initiative, referendum, candidate nominating petition or voter registration card collection effort if the basis for payment is the number of signatures obtained. This means that payment cannot be made on a per signature basis. Employment relationships that do not base payment on the number of signatures collected are allowed. Allowable practices include: paying an hourly wage or salary, using express minimum signature requirements (quota), terminating those who do not meet the productivity requirements, adjusting salaries prospectively relative to productivity, and paying discretionary bonuses based on reliability, longevity and productivity, provided no payments are made on a per signature basis. The use of express minimum signature requirements (quota) for an initiative or referendum petition is allowable so long as that requirement is disclosed to the Elections Division on the SEL 320 as part of accounts.

(3) If a circulator is carrying a petition subject to Section 1b or ORS 260.569 and another petition not subject to Section 1b or ORS 260.569 (for example, a state initiative petition and a local recall petition), the circulator may be paid by the signature only for signatures collected on the petition not subject to Section 1b or ORS 260.569. Any payment for collecting signatures on the petition subject to Section 1b or ORS 260.569 must comply with Section 1b or ORS 260.569.

(4) The phrase "directly or indirectly" in Section 1b means that the chief petitioners who are responsible for the circulation and submission of the initiative or referendum petition cannot directly pay for signature gathering based on the number of signatures obtained, and cannot contract or delegate to another person or entity to obtain signatures and allow the third party to pay circulators on the basis of the number of signatures obtained. However, chief petitioners may contract with a person or entity to manage the signature gathering, and pay the person or entity for services, including the service of qualifying the petition for the ballot, so long as the individuals who actually circulate the petition are not paid based on the number of signatures obtained. The chief petitioners are responsible for insuring that agents of the chief petitioner (anyone who is delegated the task of obtaining signatures on the initiative or referendum petition) do not violate Section 1b.

(5) Violations of Section 1b or ORS 260.569 will be processed under 260.995 as civil penalties. Penalties may be assessed against chief petitioners or any other persons who either directly or indirectly pay based on the number of signatures or voter registration cards obtained. Liability may be imposed on chief petitioners as provided in 260.561. Violations of Section 1b or 260.569 will be calculated by deeming each individual signature sheet or voter registration card that contains signatures that were collected in violation of Section 1b or 260.569 as a single occurrence.

Stat. Auth.: ORS 246.150
Stats. Implemented: ORS 250.045 & 260.995
Hist.: ELECT 15-2003, f. & cert. ef. 10-15-03; ELECT 22-2007, f. & cert. ef. 12-31-07; ELECT 15-2011, f. & cert. ef. 8-11-11; ELECT 16-2015, f. 12-31-15, cert. ef. 1-1-16; ELECT 3-2016, f. & cert. ef. 7-6-16

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Teacher Standards and Practices Commission
Chapter 584

Rule Caption: Letters of Informal Reproval; Experimental Programs; Middle Level; Licensure Processing; Teacher Leader; National Accreditation
Adm. Order No.: TSPC 3-2016(Temp)
Filed with Sec. of State: 6-30-2016
Certified to be Effective: 7-1-16 thru 12-27-16
Notice Publication Date:
Rules Adopted: 584-010-0004, 584-010-0125
Rules Amended: 584-020-0060, 584-200-0005, 584-200-0030, 584-210-0050
Subject: 584-020-0060 clarifies process for termination of informal reproval process.

584-010-0125 allows program to create innovative and collaborative programs on an experimental basis.

584-200-0005 is amended to permit applicants who previously held middle level endorsements to add foundational endorsements with only a test and to provide a 120 day grace period to all licenses that expire on June 30, 2016.

584-200-0030 defines a month as 30 days for late fees and adds a provision to allow 30 days to reopen an application if new information is received.

584-210-0050 amends provisions related to teaching experience and evaluations for Teacher Leader License.

584-010-0004 creates transition rule for national accreditation requirements.
Rules Coordinator: Tamara Dykeman—(503) 378-3586

584-010-0004
Transition to National Accreditation

(1) The Oregon Legislative Assembly has delegated to the Teacher Standards and Practices Commission the authority to establish standards for approval of educator preparation programs through Oregon Revised Statutes 342.147 and 342.165.

(2) The Oregon Legislative Assembly has required all educator preparation programs to be nationally accredited by July 1, 2022, pursuant to Sections 2 through 6, chapter 756, Oregon Laws 2015 (Enrolled SB 78).

(3) Purpose of the rule: In order to facilitate the implementation of the national accreditation requirement, the agency is establishing transition provisions for the state approval process. The purpose of the transition provisions is to provide guidance and flexibility to educator preparation programs in the state approval process as they pursue new or renewing national accreditation.

NOTE: This transition rule does not apply to educator preparation programs that have completed a site visit prior to July 1, 2016, for a pending national accreditation or state approval process.

(4) State Approval of Unit: Effective July 1, 2016, the Commission is establishing the Council for the Accreditation of Educator Preparation (CAEP) 2013 Accreditation Standards as the Oregon standards for state approval of units.

(5) In accordance with subsection (4) of this rule, the unit will not be required to meet the following standards for the state approval process:

(a) 584-017-1008 Conceptual Framework;

(b) 584-017-1015 Knowledge Skills and Professional Dispositions;

(c) 584-017-1022 Assessment System and Unit Evaluation;

(d) 584-017-1028 Selection, Recruitment, Admission and Retention of Candidates;

(e) 584-017-1038 Field Experience and Clinical Practice;

(f) 584-017-1052 Faculty Qualifications, Performances and Development; and

(g) 584-017-1055 Unit Governance and Resources.

(6) Program Review: Single Subject Endorsements: The unit may aggregate all single-subject endorsement areas into one program review report, unless the endorsement requires completion of a Commission-adopted program as provided in Chapter 584, Division 220. The Commission will provide state recognition of the aggregated single-subject programs in accordance with state standards for educator preparation (INTASC).

(7) Program Review Templates: The unit may submit a program review report in any of the following forms:

(a) TSPC Program Review Template;

(b) Specialized Professional Association (SPA) template;

(c) Modified Specialized Professional Association (SPA) template; or

(d) Any other template that meets the needs of the unit and provides the required information for TSPC program review.

(8) State-Specific Standards: State-Specific Standards (State Addendum Report): The units must submit a state addendum report for review of state-specific standards.

(a) The report must include evidence of meeting following state standards:

(A) Request for Waiver of Rules (OAR 584-017-1010);

(B) Waivers of Academic Requirements and Appeals on Academic Decisions (OAR 584-017-1012);

(C) Knowledge of School Law for Licensed Educators (OAR 584-017-1020);

(D) Diversity and Inclusion (OAR 584-017-1050);

(E) Verification of Program Completion for All Licensure Programs (OAR 584-017-1035);

(F) Field or Clinical Experiences (OAR 584-017-1042);

(G) Student Teaching (OAR 584-017-1045); and

(H) Internship Agreements (OAR 584-017-1048).

(b) The state addendum report may be submitted in conjunction with the program review process or with the state approval of unit process.

(c) The state addendum report may be submitted in the form and manner that best meets the needs of the unit, especially in regard to its national accreditation process.

NOTE: The Commission is in the process of adopting rules for statutory requirements related to reading, dyslexia and school-based clinical faculty. The unit may be required to include these areas in the state addendum report after the new rules are adopted.

(9) Applicability: Unless otherwise stated, all requirements and procedures set forth in this rule become effective July 1, 2016. This rule supersedes any provisions contained in OAR chapter 584, division 10 and 17 relating to the continuing state approval process and any conflicting rule requirements will be resolved accordingly.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.430, 342.455- 342.495 & 342.553
Hist.: TSPC 3-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

584-010-0125
Experimental Programs

(1) Purpose of Experimental Programs: The purpose of experimental licensure, endorsement or specialization programs is to allow educator preparation programs to develop innovative and creative programs that respond to community, social and education needs. Furthermore, it is to

encourage collaboration among educator preparation programs and to foster partnerships between programs and other education entities, including school districts, education service districts, private schools and non- profit organizations.

(2) Term of Experimental Programs: The Commission may provide state recognition of an experimental licensure, endorsement or specialization program for a maximum of two years. The state recognition of an experimental program may not exceed two years under any circumstances.

(3) Requirements for Experimental Programs: The proposal for state recognition of an experimental program must include:

(a) Rationale for the experimental program, including:

(A) Specific variations to Commission-adopted program requirements the unit(s) is seeking;

(B) Description of the innovative and creative program structure and how it will serve community, social and education needs; and

(C) Description of any partnerships or collaborations involved with the experimental program.

(b) Descriptions of proposed education experiences and settings;

(c) Arrangements for practica experiences;

(d) Evidence of institutional capacity to support the program; and

(e) Systematic efforts for evaluation of program completers.

(4) Requirements for Licensure: Candidates completing an experimental program must meet all Oregon licensure requirements.

(5) Annual Reports: The unit(s) must include data and information regarding any approved experimental programs within their annual report(s) to the Commission.

(6) Full State Recognition: The unit(s) must receive full state recognition of licensure, endorsement or specialization program as provided in OAR Chapter 584, Division 10 no later than two years following the date of the initial state recognition of the experimental program by the Commission.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 3-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

584-020-0060
Letters of Informal Reproval

(1) Pursuant to ORS 342.183, the Commission may agree not to pursue disciplinary action against a licensed, registered or certified educator by the Commission and issue a letter of informal reproval if:

(a) Following an investigation, the Commission determines that the educator has engaged in misconduct based on standards adopted by the Commission by rule; and

(b) The educator agrees to the terms of the letter of informal reproval, including a monitoring period.

(2) The Commission may take disciplinary action if the educator fails to comply with the terms of the informal reproval as provided in subsection (5) of this rule.

(3) Pursuant to ORS 342.183, the Commission shall:

(a) Establish the terms of a monitoring period for the educator to whom the letter is issued; and

(b) Notify the employer, if any, of the educator to whom the letter is issued, including any terms of the letter that the employer may need to know to assist the educator in complying with the terms of the letter.

(4) A letter of reproval:

(a) Is confidential; and

(b) May not be posted on an interstate clearinghouse related to educator license sanctions except if disciplinary action is taken as provided in subsection (5) of this rule.

(5) If an educator fails to comply with the terms of a letter of informal reproval, the Commission may take disciplinary action against the educator based on one or both of the following:

(a) The conduct underlying the letter of informal reproval; or

(b) The failure to comply with the terms of the letter of informal reproval.

(6) If the Executive Director of the Commission determines that an educator failed to meet the terms of a letter of informal reproval, the Executive Director is authorized to open an investigation into the alleged failure and shall submit the investigation report to the Commission with a recommendation regarding potential sanctions to make a final determination pursuant to ORS 342.176.

(7) If the Executive Director of the Commission determines that an educator has met the terms of a letter of informal reproval and has successfully completed the monitoring period, the Executive Director is authorized to terminate the monitoring period and issue a letter dismissing the Informal Letter of Reproval and Monitoring Period.

(a) All dismissal letters terminating an Informal Letter of Reproval and monitoring period shall be reported to the Commission at the meeting following the date of the Dismissal Order.

(b) The investigation file, record of Informal Letter of Reproval and the dismissal letter are confidential and not subject to public disclosure.

(8) The Executive Director shall notify the educator by letter of the dismissal of the informal reproval as provided in subsection (7) of this rule.

(9) The Executive Director shall notify the employer, if any, of the educator who was previously notified under subsection (3)(b) of this rule of the dismissal of the informal reproval as provided in subsection (7) of this rule.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.175 - 342.190
Hist.: TSPC 1-2015, f. & cert. ef. 2-10-15; TSPC 3-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

584-200-0005
Transition to New Licensure System

(1) Effective January 1, 2016: All OAR Chapter 584 rule titles, numbers and provisions adopted on or after January 1, 2016 will supersede all OAR Chapter 584 rule numbers, titles and provisions adopted prior to this date. Any conflicting rule requirements within OAR Chapter 584 will be resolved according to the OAR Chapter 584 rule provisions effective on or after January 1, 2016.

(2) Endorsements:

(a) Effective July 1, 2015, the endorsements as provided in OAR 584-220-0010 will be placed on first-issue licenses and renewals.

(b) Effective July 1, 2015, all teaching licenses will be issued endorsement in accordance with Division 220, Endorsements on Teaching Licenses and subsection (2)(c) of this rule.

(c) Multiple Subjects — Middle Level Endorsements: Effective July 1, 2015, the Multiple Subjects — Middle Level endorsement is abolished. The Multiple Subjects — Middle Level endorsement will not be added to or retained with an applicant's Initial, Initial I, Initial II, Continuing, Professional Teaching Licenses or any future licenses the applicant holds. Current holders of the Multiple Subjects — Middle Level endorsement will be subject to the following transition provisions:

(A) If the applicant has been assigned and taught multiple subjects (self-contained) for four full years or more in a public, charter or private school setting as evidenced by Professional Educational Experience Report (PEER) forms, the Elementary-Multiple Subjects endorsement may be added to the license. If the applicant has not taught four full years or more in an assignment that requires a multiple subjects (self-contained) endorsement, the Elementary-Multiple Subjects endorsement may not be added to the license. If necessary, the applicant and an Oregon school district may apply for an Emergency Teaching License pursuant to OAR 584-210-0130 or a License for Conditional Assignment (LCA) pursuant to OAR 584-210-0160 while the applicant is in the process of qualifying for an Elementary — Multiple Subjects or another valid endorsement.

(B) If the applicant has been assigned and taught Foundational Mathematics, Foundational Language Arts, Foundational Social Studies or Foundational Science for four full years or more in a public, charter or private school setting, as evidenced by Professional Educational Experience Report (PEER) forms, the appropriate foundational single subject may be added to the license. If the applicant has not taught four full years in an assignment that requires a foundational subject matter endorsement, the foundational subject matter endorsement may not be added to or retained on the license. If necessary, the applicant and a district may apply for an Emergency Teaching License pursuant to OAR 584-210-0130 or a License for Conditional Assignment (LCA) pursuant to 584-210-0160 while the applicant is in the process of qualifying for a valid subject-matter endorsement. The applicant may add the Foundational Mathematics, Foundational Language Arts, Foundational Social Studies or Foundational Science by receiving a passing score of the appropriate Commission-approved subject mastery test. The applicant is not required to complete the pedagogy requirements for adding an endorsement to a Preliminary Teaching License as provided in Chapter 584, Division 220.

(3) Grade-Level Authorizations:

(a) Effective July 1, 2015, grade-level authorizations for Initial, Initial I, Initial II, Continuing, Professional Teaching and Distinguished Teacher Leader licenses are abolished and regardless of the printed grade authorizations held on the license, all licenses in this subsection are authorized prekindergarten through grade 12 within the scope of the NCES course codes associated with the endorsements held on the license.

(b) Effective January 1, 2016, grade-level authorizations for Basic and Standard teaching licenses are abolished and regardless of the printed

grade authorizations held on the license, all licenses are authorized prekindergarten through grade 12 within the scope of the NCES course codes associated with the endorsements held on the license.

(c) Effective July 1, 2015, licensees will no longer be advised that they must add a grade-level authorization program in order to expand the grade levels on their license.

(d) Licensees advised they were required to complete a grade-level authorization program will not be held for failure to complete that requirement.

(e) The Commission will make every effort to identify these licensees to alert them to the new grade-level authorization requirements.

(4) Initial I Teaching Licenses: (a) All applicants issued an Initial I Teaching License between July 1, 2015 and December 31, 2015 will be issued a renewal of their license in accordance with the Preliminary Teaching License adopted on January 1, 2016.

(b) Effective January 1 2016, the Initial I Teaching License will be administratively renamed to the Preliminary Teaching License.

(5) Initial I and Initial II Teaching Licenses Based on a MAT or Post-Baccalaureate Preparation Program issued prior to July 1, 2015: General Provisions: Effective July 1 2015, the completion of the advanced coursework of six (6) semester or nine (9) quarter graduate hours required to advance to the Initial II Teaching License satisfies the advanced professional education program requirements for the Professional Teaching License.

(6) Initial I Teaching Licenses Based on a Bachelor's Degree issued prior to July 1, 2015: General Provisions: Effective July 1, 2015, for Initial I Teaching Licenses based on a Bachelor's degree, the requirements to complete the master's degree or equivalent post-Initial I Teaching License are modified as follows:

(a) Admission to and completion of a master's degree or higher in education or in the arts and sciences from a regionally accredited institution, or the foreign equivalent of such degree approved by the Commission will satisfy the advanced professional education program requirements of the Professional Teaching License;

(b) Completion of thirty (30) semester hours or forty-five (45) quarter hours of graduate coursework will be considered "equivalent" to completion of a master's degree;

(c) Effective July 1, 2015, the requirement that "equivalent" graduate coursework must include equal amounts of pedagogy; content; and electives (ten (10) semester or fifteen (15) quarter graduate hours each) has been eliminated; and

(d) Applicants who do not wish to complete these requirements may qualify for promotion to the Professional Teaching License upon completion of the advanced program requirements as provided in OAR 584-0210-0040.

(7) Initial I Teaching Licenses Based on a MAT or Post-Baccalaureate Preparation Program Issued Between July 1, 2012 through June 30, 2015: First Renewal: (a) Upon the first renewal of the Initial I Teaching License, applicants will be issued a new set of instructions for qualifying for the Professional Teaching License.

(b) Qualified applicants will be issued an Initial I Teaching license which will be administratively renamed to a Preliminary Teaching License after January 1, 2016.

(c) To qualify for first renewal of the Initial I Teaching License, an applicant subject to this subsection must:

(A) Meet the previously advised renewal requirements to show progress of 3 semester or 4.5 quarter hours (at least 90 professional development units); or

(B) Meet the new Preliminary Teaching License renewal requirements as provided in OAR 584-210-0030.

(d) If the applicant does not meet renewal requirements for either previously advised or new Preliminary Teaching License renewal options, the applicant may not renew the license. The applicant may apply to reinstate the Preliminary Teaching License upon completion of the renewal requirements in effect at the time of application for reinstatement. (See, OAR 584-210-0030 and OAR 584-210-0190.)

(e) Failure to complete renewal requirements is not considered an eligible emergency for purposes of the Emergency Teaching License.

(8) Initial I Teaching Licenses Based on a Bachelor's Degree Issued Between July 1, 2012 through June 30, 2015: First Renewal: (a) Upon the first renewal of the Initial I Teaching License, applicants will be issued a new set of instructions for the requirements to qualify for the Professional Teaching License.

(b) Qualified applicants will be issued an Initial I Teaching license which will be administratively renamed to a Preliminary Teaching License after January 1, 2016.

(c) To qualify for first renewal of the Initial I Teaching License, an applicant subject to this subsection must:

(A) Meet the previously advised renewal requirements of 3 semester or 4.5 quarter hours (at least 90 professional development units); or

(B) Meet the new Preliminary Teaching License renewal requirements as provided in OAR 584-210-0030.

(d) If the applicant does not meet renewal requirements for either the previously advised renewal option or the new Preliminary Teaching License renewal option, the applicant may not renew the license. The applicant may apply to reinstate the Preliminary Teaching License upon completion of the renewal requirements in effect at the time of application for reinstatement.

(e) Generally, failure to complete renewal requirements is not considered an eligible emergency for purposes of the Emergency Teaching License.

(9) Initial I Teaching Licenses Based on a Bachelor's Degree First Issued Between July 1, 2009 through June 30 2012: Second Renewal:

(a) Upon second and final renewal of the Initial I Teaching License, applicants will be issued a new set of instructions for the requirements that must be completed in order to obtain the Professional Teaching License.

(b) Qualified applicants will be issued an Initial I Teaching license which will be administratively renamed to a Preliminary Teaching License after January 1, 2016.

(c) To qualify for second renewal of the Initial I Teaching License, an applicant subject to this subsection must:

(A) Meet the previously advised renewal requirements to show progress of 3 semester or 4.5 quarter hours (at least 90 professional development units); or

(B) Meet the new Preliminary Teaching License renewal requirements as provided in OAR 584-210-0030.

(d) If the applicant does not meet renewal requirements for either the previously advised renewal option or the new Preliminary Teaching License renewal option, the applicant may not renew the license. The applicant may apply to reinstate the Preliminary Teaching License upon completion of the renewal requirements in effect at the time of application for reinstatement.

(e) Generally, failure to complete renewal requirements is not considered an eligible emergency for purposes of the Emergency Teaching License.

(f) If an applicant is eligible for the Professional Teaching License as provided in OAR 584-210-0040, the applicant will be issued the Professional Teaching License.

(10) Initial I Teaching Licenses Based on a MAT or Post-Baccalaureate Preparation Program Issued Between July 1, 2009 through June 30, 2012:

(a) Qualified applicants who have completed the advanced professional education program requirements and the professional experience requirement as previously advised by the Commission will be issued the Professional Teaching License.

(b) To qualify for the Professional Teaching License, applicants subject to this subsection must:

(A) Meet previously advised advanced coursework requirement of six (6) semester or nine (9) quarter graduate hours; or

(B) Meet the new requirements for the Professional Teaching License as provided in OAR 584-210-0040. Under this option, the applicant may use any qualifying coursework earned during the first two terms of her or his Initial I Teaching License to satisfy the new advanced professional education program requirements.

(c) If an applicant is unable to meet requirements for the Professional Teaching License as provided in subsection (10)(b) of this rule, the applicant will be issued a renewal of the Preliminary Teaching License.

(d) To qualify for the Professional Teaching License, all applicants must also meet the professional experience requirements provided in OAR 584-210-0040, Professional Teaching License.

(11) Initial I Teaching Licenses Based on a Bachelor's Degree First Issued Between July 1, 2006 through June 30, 2009: No Further Renewals:

(a) Qualified applicants who have completed the advanced coursework requirements as previously advised by the Commission and the professional experience requirement will be issued the Professional Teaching License;

(b) To qualify for the Professional Teaching License, applicants subject to this subsection must:

(A) Meet previously advised advanced master's degree or equivalent coursework requirements for the Initial II Teaching License as modified by subsection (5) and (6) of this rule; or

(B) Meet the new requirements for the Professional Teaching License as provided in OAR 584-210-0040. Under this option, the applicant may use any qualifying coursework earned during the first two terms of her or his Initial I Teaching License to satisfy the new advanced professional education program requirements.

(c) If an applicant is unable to meet requirements for the Professional Teaching License provided in subsection (10)(b) of this rule, the applicant will be issued a renewal of the Preliminary Teaching License.

(d) To qualify for the Professional Teaching License, all applicants must also meet the professional experience requirements provided in OAR 584-210-0040, Professional Teaching License.

(12) Initial II Teaching Licenses Effective July 1, 2015:

(a) Effective July 1, 2015, the Initial II Teaching License will no longer be issued.

(b) Qualified applicants who were issued the Initial II Teaching License prior July 1, 2015 are considered to have satisfied all advanced professional education program requirements provided in OAR 584-210-0040, Professional Teaching License;

(c) Qualified applicants who have completed the teaching experience requirements provided in OAR 584-210-0040 will be issued the Professional Teaching License;

(d) Qualified applicants who do not have sufficient teaching experience to meet the requirements for OAR 584-210-0040, Professional Teaching License, will be issued a continuously renewable Preliminary Teaching License as provided in OAR 584-210-0030, Preliminary Teaching License.

(e) On January 1, 2016, the Initial I Teaching License will be administratively renamed to the Preliminary Teaching License.

(13) Continuing Teaching Licenses:

(a) Effective March 1, 2014, the Continuing Teaching License is no longer issued.

(b) Qualified Continuing Teaching License holders will be issued a Professional Teaching License with instructions on how to qualify and apply for the Teacher Leader License;

(14) Basic Teaching Licenses:

(a) Effective January 1, 2016, the Basic Teaching License will no longer be issued.

(b) Qualified applicants who were issued the Basic Teaching License prior to December 31, 2015 are considered to have satisfied all advanced professional education program requirements provided in OAR 584-210-0040, Professional Teaching License;

(c) Qualified applicants who have completed the teaching experience requirements provided in OAR 584-210-0040 will be issued the Professional Teaching License;

(d) Qualified applicants who do not have sufficient teaching experience to meet the requirements for OAR 584-210-0040, Professional Teaching License, will be issued the Legacy Teaching License unless the applicant requests to have the Preliminary Teaching License.

(15) Standard Teaching License Renewals:

(a) Effective January 1, 2016, the Standard Teaching License will no longer be issued.

(b) Qualified Standard Teaching License holders will be issued a Professional Teaching License.

(16) First Time Out of State Applicants:

(a) Effective January 1, 2016, the Initial Teaching License will no longer be issued.

(b) Qualified new out of state applicants will be issued a Reciprocal Teaching License as provided in OAR 584-210-0060.

(17) Five Year Teaching Licenses (Pre-1965 licenses) Renewals:

(a) Effective January 1, 2016, the pre-1965 Five Year Teaching Licenses will no longer be issued.

(b) Qualified Five Year Teaching License holders will be issued either the Professional Teaching License.

(18) Teaching Licenses with Communication Disorder endorsements (speech language pathology):

(a) Effective January 1, 2016, all speech pathology related endorsements are retitled to Special Education: Communication Disorders.

(b) Until June 30, 2016, qualified applicants may be issued new non-provisional teaching licenses with special education: communications disorder endorsements.

(c) Effective July 1, 2016, new special education: communication disorder endorsements (speech language pathology) will no longer be issued.

(d) Effective July 1, 2016, licensed educators issued a non-provisional special education: communication disorder endorsements or other similar speech language pathology endorsements prior to June 30, 2016 are grandfathered into the licensure system and will be able to keep their special education: communication disorder endorsement. Grandfathered qualified applicants will be able to renew and reinstate teaching licenses with the special education: communication disorder endorsement. Applicants may not reinstate a restricted teaching license with a communication disorder or other similar speech pathology endorsement.

(19) Endorsements transitioning to Specializations:

(a) Early Childhood: All licenses issued prior to January 1, 2016 with an early childhood authorization or endorsement will be issued an early childhood specialization upon renewal of the license.

(b) ESOL/Bilingual: All licenses issued prior to January 1, 2016 with an ESOL/Bilingual endorsement will be issued an ESOL endorsement with a bilingual specialization upon renewal of the license.

(20) ESEA Alternative Route Teaching License Transition: Effective January 1, 2016, the ESEA Alternative Route Teaching License is no longer issued. Qualified applicants issued an ESEA license prior to January 1, 2016 must transition to full licensure at the end of their current three-year license term.

(21) Administrative and Personnel Service License Title Name Changes: Effective January 1, 2016, administrative and personnel service educator licenses titles will be renamed as follows:

(a) Basic Administrator is retitled to Legacy Preliminary Administrator;

(b) Standard Administrator is retitled to Professional Administrator;

(c) Initial Administrator is retitled to Preliminary Administrator;

(d) Continuing Administrator is retitled to Professional Administrator;

(e) Distinguished Administrator is retitled to Distinguished Administrator;

(f) Transitional Administrator is retitled to Reciprocal Administrator;

(g) Transitional Superintendent is retitled to Reciprocal Superintendent;

(h) Restricted Administrator is retitled to Restricted Administrator;

(i) Exceptional Administrator is retitled to Exceptional Administrator;

(j) Emergency Administrator is retitled to Emergency Administrator;

(k) Basic Personnel Service with a Basic or Standard Counselor endorsement is retitled to Legacy School Counselor;

(l) Basic Personnel Service with a Basic or Standard School Psychologist endorsement is retitled to Legacy School Psychologist;

(m) Standard Personnel Service with a Standard Counselor endorsement is retitled to Professional School Counselor;

(n) Standard Personnel Service with a Standard School Psychologist endorsement is retitled to Professional School Psychologist;

(o) Standard School Counselor is retitled to Professional School Counselor;

(p) Initial I School Counselor is retitled to Preliminary School Counselor;

(q) Initial II School Counselor is retitled to Preliminary School Counselor;

(r) Continuing School Counselor is retitled to Professional School Counselor;

(s) Transitional School Counselor is retitled to Reciprocal School Counselor;

(t) Restricted School Counselor is retitled to Restricted School Counselor;

(u) Emergency School Counselor is retitled to Emergency School Counselor;

(v) Basic School Psychologist is retitled to Preliminary School Psychologist;

(w) Standard School Psychologist is retitled to Professional School Psychologist;

(x) Initial School Psychologist is retitled to Preliminary School Psychologist;

(y) Continuing School Psychologist is retitled to Professional School Psychologist;

(z) Transitional School Psychologist is retitled to Reciprocal School Psychologist;

(aa) Limited Student Services is retitled to Limited Student Services;

(bb) Initial School Social Worker is retitled to Preliminary School Social Worker;

(cc) Continuing School Social Worker is retitled to Professional School Social Worker;

(dd) Transitional School Social Worker is retitled to Reciprocal School Social Worker;

(ee) Restricted School Social Worker is retitled to Restricted School Social Worker; and

(ff) Emergency School Social Worker is retitled to Emergency School Social Worker.

(22) June 30, 2016 Grace Periods: Notwithstanding OAR 584-200-0030(4)(d) and Chapter 584, Division 210, all licenses with an expiration date of June 30, 2016 will receive a 120 grace period in accordance with OAR 584-200-0030(4).

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.430, 342.455 - 342.495 & 342.553
Hist.: TSPC 13-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; TSPC 1-2016, f. & cert. ef. 2-10-16; TSPC 3-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

584-200-0030
Application Processing Requirements and Procedures

(1) All applicants must create an online user account and use the online system for applications for licenses, endorsements, renewals, specializations, and reinstatements.

(2) All applicants must pay for fees through the online system. Check and cash payments are not permitted.

(3) Requirement for Complete Application: The Commission will only process complete applications for new licenses, endorsements, renewals, specializations and reinstatements. An application is incomplete if the applicant has not submitted a correct and complete application, all required fee payments, and all supporting documentation required to evaluate the application.

(4) Evaluation of Application: Licenses, registrations and certificates are issued based on the evidence in the applicant account at the time of evaluation. If an applicant submits additional acceptable evidence within 30 days of the date of issuance of a license, registration or certificate, the Director of Licensure, or designee, may reevaluate the issuance without a new application and fee.

EXAMPLE: An applicant is issued a Preliminary Teaching License. The applicant submits new acceptable documentation of experience within 30 days of the issuance of the Preliminary Teaching License. The Director of Licensure, or designee, may reevaluate the applicant for the Professional Teaching License based on the new evidence without requiring a new application and fee.

EXAMPLE: An applicant is moving from a Reciprocal Teaching License to a Preliminary Teaching License. The applicant is issued a Preliminary Teaching License with endorsements based on evidence available in the applicant account of acceptable documentation of content knowledge as provided in OAR Chapter 584, Division 220. The applicant submits additional test scores within 30 days of issuance of the Preliminary Teaching Licensee. The Director of Licensure, or designee, may reevaluate the applicant for new endorsements based on the new test scores without requiring a new application and fee.

(5) Expiration of License: A license, certificate or registration is expired one day after the expiration date on the license, certificate or registration unless the license, registration or certificate is eligible for the grace period.

(a) The grace period is active for 120 days after the expiration date of a license, registration and certificate.

(b) To activate the 120 day grace period, an applicant must submit a correct and complete application and all required fees prior to the expiration date.

(A) If it is determined that the application was not correct or complete after the grace period is activated, the applicant has the remainder of the 120 grace period to correct the incomplete application.

(B) If the application is not corrected by the expiration of the 120 day grace period, the applicant must submit a new application for reinstatement of the license, registration or certificate and pay reinstatement fees. The applicant will forfeit the previous application fees and any late fees paid on the prior application.

(c) If an applicant submits a correct and complete application and all required fees after the expiration date, the license, registration or certificate will be processed according to the following provisions:

(A) Day 1 to 30: If an applicant submits a correct and complete application from one to 30 days after expiration date, the applicant pays $40 late fees plus all other required fees. The applicant will receive a grace period from the date of application until 120 days after the expiration date;

(B) Day 31 to 60: If an applicant submits a correct and complete application from 31 to 60 days after expiration date, the applicant pays $80 late fees plus all other required fees. The applicant will receive a grace period from the date of application until 120 days after the expiration date;

(C) Day 61 to 90: If an applicant submits a correct and complete application from 61 to 90 days after expiration date, the applicant pays $120 late fees plus all other required fees. The applicant will receive a grace period from the date of application until 120 days after the expiration date;

(D) Day 91 to 120: If an applicant submits a correct and complete application from 91 to 120 days after expiration date, the applicant pays $160 late fees plus all other required fees. The applicant will receive a grace period from the date of application until 120 days after the expiration date;

(E) Day 121 or more: Applicant pays for new application for reinstatement, reinstatement fees and all other required fees.

(F) If an applicant submits a correct a complete application prior to the expiration of the 120 day grace period, the renewal period of the license, registration or certificate will start one day after the original expiration date.

(d) The following licenses are not eligible for 120 grace period due to renewal restrictions:

(A) Emergency licenses; (Not eligible for renewal);

(B) Restricted licenses; (Eligible for reissue only);

(C) International Visiting Teacher License: (Eligible for reissue only);

(D) Restricted Substitute Teaching License if issued for one-year term;

(E) License for Conditional Assignment. (Eligible for reauthorization only).

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.430, 342.455 - 342.495 & 342.553
Hist.: TSPC 13-2015(Temp), f. 11-13-15, cert. ef. 1-1-16 thru 6-28-16; TSPC 1-2016, f. & cert. ef. 2-10-16; TSPC 3-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

584-210-0050
Teacher Leader License

(1) Purpose of the License: The Teacher Leader License is issued to professional teachers who have demonstrated exceptional leadership in the school environment, education profession and the larger community while consistently advancing student growth and achievement. The Teacher Leader License designates that the licensee is qualified to hold the title of Teacher Leader and to provide educational leadership that may include, but is not limited to: mentoring, curriculum development support, teacher preparation support and other leadership activities consistent with the Teacher Leader Standards adopted by the Commission.

(2) Teacher Leader Pilot Project: Effective July 1, 2015 the Commission commenced a two year pilot for implementation of this rule. The pilot is intended to gather sufficient information to ensure that future issuance of the license is based on an evaluation of evidence submitted and verified to be in alignment with the Teacher Leaders standards adopted by the Commission and statutory provisions adopted by the Oregon State Legislature. This rule is effective until June 30, 2017. Prior to this date, the Commission will adopt a revised Teacher Leader License rule based on the results of the pilot project.

(3) Term of Licensure: The Teacher Leader License is valid for five years and is renewable as provided in subsection (10) of this rule. The date of the first expiration of the license is five years from the date of issue plus time until the applicant's birthday.

(4) Assignment and Endorsement Authorization: The Teacher Leader License qualifies the teacher to accept:

(a) Any instructional assignment from preprimary through grade 12 within the scope of the subject-matter endorsements held on the Professional Teaching License;

(b) Any substitute teaching assignments; and

(c) Teacher leader activities, as agreed upon with any employing school district, as provided in subsection (1) of this rule.

(5) Evidence of Effectiveness: To be eligible to qualify for a Teacher Leader License, an applicant must be deemed to be effective or highly effective as provided in ORS 342.856 and the following provisions.

(a) The applicant must provide evidence of two evaluations with an "effective" or "highly effective" level. The evaluations must be completed:

(A) Within the five years immediately preceding the application for the Teacher Leader license; and

(B) While the applicant held an Initial II, Continuing, Standard or Professional Teaching License.

(b) The applicant must verify that they have not received an evaluation with lower than an "effective" level within the five years immediately preceding the application for the Teacher Leader license.

(c) The terms "effective" and "highly effective" include the top two differentiated levels established as provided in the Oregon Department of Education's "Oregon Matrix Model for Educator Evaluation." Other acceptable evaluation terms may include, but are not limited to: proficient, exemplary, accomplished, or distinguished.

(d) If an applicant is employed by a private school, the applicant must verify that their school evaluates educators in accordance with the requirements of ORS 342.856. The applicant must provide documentation that the

employing private school formally adopted the equivalent evaluation method in a meeting of the governing body.

(6) Evidence of Current Professional Leadership Practices: To be eligible to qualify for a Teacher Leader License, an applicant must submit evidence of current professional leadership practices as provided in ORS 342.856.

(a) To submit an advanced portfolio of "current professional leadership practices" the evidence must:

(A) Align with the standards for the Teacher Leader License as provided in OAR 584-420-0040;

(B) Have occurred within the five years immediately prior to the application for the Teacher Leader License; and

(C) Meet the following criteria:

(i) The applicant must demonstrate through submitted documentation that they have fully met at least twelve (12) elements of the existing thirty-seven (37) elements under any of the seven (7) domains within the standards for the Teacher Leader License;

(ii) The evidence for each element submitted must be verified as valid by at least two professional colleagues, which may include coworkers, supervisors, or other professional peers; and

(iii) The evidence for each element submitted must be unique and separate. For example, an applicant may not reuse evidence from one element to support meeting another element.

(b) To submit National Board for Professional Teacher Standards Certification to demonstrate "current professional leadership practices" the evidence must:

(A) Show the national board certification occurred in the five years immediately prior to the application; and

(B) Demonstrate how board certification and subsequent professional practice by the teacher meets at least twelve (12) elements of the existing thirty-seven (37) elements under any of the seven (7) domains within the standards for the Teacher Leader License.

(c) To submit admission to and completion of a Commission-approved teacher leader program to demonstrate "current professional leadership practices" evidence, the applicant must provide documentation that:

(A) The program was completed in the five years immediately prior to the application; and

(B) The completion of the Commission-approved teacher leader preparation program and subsequent professional practice by the teacher meets at least twelve (12) elements of the existing thirty-seven (37) elements under any of the seven (7) domains within the standards for the Teacher Leader License.

(7) To be eligible to apply for a Teacher Leader License, an applicant must:

(a) Possess the personal qualifications for licensure including attainment of at least eighteen (18) years of age and possessing good moral character and mental and physical health necessary for employment as an educator;

(b) Hold a valid Professional, Initial II or Standard teaching License;

(c) Have been employed as a licensed educator for five full academic school years within the five years preceding application;

(d) Meet the "evidence of effectiveness" requirements as provided in subsection (5) of this rule;

(e) Meet the "evidence of current professional leadership practices" requirements as provided in subsection (6) of this rule;

(f) Submit the adopted the Rubric for Teacher Leader Evaluation for review by the Commission. The applicant must indicate the exact evidence they are using to satisfy each of their selected elements. There must be a clear indication on the evidence which of the elements the evidence is being submitted to support;

(g) Complete a background clearance that includes:

(A) Furnishing fingerprints (if necessary);

(B) Providing satisfactory responses to character questions in the form and manner prescribed by the Commission; and

(h) Submit a complete and correct application in the form and manner required by the Commission, including payment of all required fees as provided in OAR 584-200-0050.

(8) All applications for the Teacher Leader License must be received in the TSPC office no later than one calendar month prior to the Commission meeting at which the applicant wishes to have their application evaluated.

(9) All current teaching licenses held prior the application for the Teacher Leader License will expire on the date the Teacher Leader License is issued regardless of the expiration date on the license.

(10) Renewal Requirements: To be eligible to apply for renewal of the Teacher Leader License, an applicant must:

(a) Provide documentation of ongoing teacher leader activities, including but not limited to, mentoring, curriculum development support, teacher preparation support and other educational leadership activities;

(b) Complete professional development units as provided in OAR 584-255-0010 Professional Development Requirements; and

(c) Submit a complete and correct renewal application in the form and manner required by the Commission, including payment of all required fees as provided in OAR 584-200-0050.

(11) If an applicant does not meet the renewal requirements of subsection (10) of this rule or decides not to renew the Teacher Leader License, the applicant may apply for or will be issued a Professional Teaching License as provided in OAR 584-210-0040.

(12) Sunset Clause: This rule is effective until July 1, 2017.

Stat. Auth.: ORS 342

Stats. Implemented: ORS 342.120 - 342.430, 342.455 - 342.495 & 342.553

Hist.: TSPC 12-2015, f. 11-13-15, cert. ef. 1-1-16; TSPC 1-2016, f. & cert. ef. 2-10-16; TSPC 3-2016(Temp), f. 6-30-16, cert. ef. 7-1-16 thru 12-27-16

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
101-020-0060	7-12-2016	Amend	8-1-2016
101-020-0065	7-12-2016	Amend	8-1-2016
101-030-0015	7-12-2016	Amend	8-1-2016
101-030-0020	7-12-2016	Repeal	8-1-2016
104-080-0000	12-1-2015	Amend	1-1-2016
104-080-0010	12-1-2015	Repeal	1-1-2016
104-080-0020	12-1-2015	Repeal	1-1-2016
104-080-0021	12-1-2015	Repeal	1-1-2016
104-080-0022	12-1-2015	Repeal	1-1-2016
104-080-0023	12-1-2015	Repeal	1-1-2016
104-080-0024	12-1-2015	Repeal	1-1-2016
104-080-0025	12-1-2015	Repeal	1-1-2016
104-080-0026	12-1-2015	Repeal	1-1-2016
104-080-0027	12-1-2015	Repeal	1-1-2016
104-080-0028	12-1-2015	Repeal	1-1-2016
104-080-0030	12-1-2015	Repeal	1-1-2016
104-080-0040	12-1-2015	Repeal	1-1-2016
104-080-0050	12-1-2015	Repeal	1-1-2016
104-080-0060	12-1-2015	Repeal	1-1-2016
104-080-0070	12-1-2015	Repeal	1-1-2016
104-080-0100	12-1-2015	Adopt	1-1-2016
104-080-0110	12-1-2015	Adopt	1-1-2016
104-080-0120	12-1-2015	Adopt	1-1-2016
104-080-0125	12-1-2015	Adopt	1-1-2016
104-080-0135	12-1-2015	Adopt	1-1-2016
104-080-0140	12-1-2015	Adopt	1-1-2016
104-080-0150	12-1-2015	Adopt	1-1-2016
104-080-0160	12-1-2015	Adopt	1-1-2016
104-080-0165	12-1-2015	Adopt	1-1-2016
104-080-0170	12-1-2015	Adopt	1-1-2016
104-080-0180	12-1-2015	Adopt	1-1-2016
104-080-0190	12-1-2015	Adopt	1-1-2016
104-080-0195	12-1-2015	Adopt	1-1-2016
104-080-0200	12-1-2015	Adopt	1-1-2016
104-080-0210	12-1-2015	Adopt	1-1-2016
105-010-0000	7-1-2016	Repeal	8-1-2016
105-010-0011	7-1-2016	Repeal	8-1-2016
105-010-0016	7-1-2016	Repeal	8-1-2016
105-020-0001	7-1-2016	Amend	8-1-2016
105-020-0015	7-1-2016	Amend	8-1-2016
105-040-0001	7-1-2016	Amend	8-1-2016
105-040-0010	7-1-2016	Repeal	8-1-2016
105-040-0020	7-1-2016	Repeal	8-1-2016
105-040-0030	7-1-2016	Repeal	8-1-2016
105-040-0040	3-1-2016	Amend(T)	3-1-2016
105-040-0040(T)	7-1-2016	Repeal	8-1-2016
105-040-0050	7-1-2016	Repeal	8-1-2016
105-040-0060	7-1-2016	Repeal	8-1-2016
105-040-0065	3-1-2016	Amend(T)	3-1-2016
105-040-0065(T)	7-1-2016	Repeal	8-1-2016
105-040-0070	7-1-2016	Repeal	8-1-2016
105-040-0080	7-1-2016	Repeal	8-1-2016
105-050-0003	7-1-2016	Amend	8-1-2016
105-050-0004	7-1-2016	Amend	8-1-2016
105-050-0006	7-1-2016	Repeal	8-1-2016
105-050-0025	7-1-2016	Amend	8-1-2016
105-050-0030	7-1-2016	Amend	8-1-2016
111-005-0010	6-10-2016	Amend(T)	7-1-2016
111-005-0015	6-10-2016	Amend(T)	7-1-2016
111-005-0020	6-10-2016	Amend(T)	7-1-2016
111-005-0040	6-10-2016	Amend(T)	7-1-2016
111-005-0042	6-10-2016	Amend(T)	7-1-2016
111-005-0044	6-10-2016	Amend(T)	7-1-2016
111-005-0046	6-10-2016	Amend(T)	7-1-2016
111-005-0047	6-10-2016	Amend(T)	7-1-2016
111-005-0048	6-10-2016	Amend(T)	7-1-2016
111-005-0050	6-10-2016	Amend(T)	7-1-2016
111-005-0055	6-10-2016	Amend(T)	7-1-2016
111-005-0080	6-10-2016	Amend(T)	7-1-2016
123-021-0010	4-11-2016	Amend(T)	5-1-2016
123-021-0010	6-3-2016	Amend	7-1-2016
123-021-0010(T)	6-3-2016	Repeal	7-1-2016
123-021-0015	4-11-2016	Amend(T)	5-1-2016
123-021-0015	6-3-2016	Amend	7-1-2016
123-021-0015(T)	6-3-2016	Repeal	7-1-2016
123-021-0020	4-11-2016	Amend(T)	5-1-2016
123-021-0020	6-3-2016	Amend	7-1-2016
123-021-0020(T)	6-3-2016	Repeal	7-1-2016
123-021-0050	4-11-2016	Amend(T)	5-1-2016
123-021-0050	6-3-2016	Amend	7-1-2016
123-021-0050(T)	6-3-2016	Repeal	7-1-2016
123-021-0080	4-11-2016	Amend(T)	5-1-2016
123-021-0080	6-3-2016	Amend	7-1-2016
123-021-0080(T)	6-3-2016	Repeal	7-1-2016
123-021-0090	4-11-2016	Amend(T)	5-1-2016
123-021-0090	6-3-2016	Amend	7-1-2016
123-021-0090(T)	6-3-2016	Repeal	7-1-2016
123-021-0110	4-11-2016	Amend(T)	5-1-2016
123-021-0110	6-3-2016	Amend	7-1-2016
123-021-0110(T)	6-3-2016	Repeal	7-1-2016
123-042-0020	2-29-2016	Amend	4-1-2016
123-042-0020(T)	2-29-2016	Repeal	4-1-2016
123-042-0026	2-29-2016	Amend	4-1-2016
123-042-0026(T)	2-29-2016	Repeal	4-1-2016
123-042-0036(T)	2-29-2016	Repeal	4-1-2016
123-042-0038	2-29-2016	Amend	4-1-2016
123-042-0038(T)	2-29-2016	Repeal	4-1-2016
123-042-0045	2-29-2016	Amend	4-1-2016
123-042-0045(T)	2-29-2016	Repeal	4-1-2016
123-042-0055	2-29-2016	Amend	4-1-2016
123-042-0055(T)	2-29-2016	Repeal	4-1-2016
123-042-0061	2-29-2016	Adopt	4-1-2016
123-042-0065(T)	2-29-2016	Repeal	4-1-2016
123-042-0076	2-29-2016	Amend	4-1-2016
123-042-0076(T)	2-29-2016	Repeal	4-1-2016
123-042-0122	2-29-2016	Amend	4-1-2016
123-042-0122(T)	2-29-2016	Repeal	4-1-2016
123-042-0132	2-29-2016	Amend	4-1-2016
123-042-0132(T)	2-29-2016	Repeal	4-1-2016
123-042-0155	2-29-2016	Amend	4-1-2016
123-042-0155(T)	2-29-2016	Repeal	4-1-2016
123-042-0165	2-29-2016	Amend	4-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
123-042-0165(T)	2-29-2016	Repeal	4-1-2016
123-042-0175	2-29-2016	Amend	4-1-2016
123-042-0175(T)	2-29-2016	Repeal	4-1-2016
123-042-0180	2-29-2016	Amend	4-1-2016
123-042-0180(T)	2-29-2016	Repeal	4-1-2016
123-042-0190(T)	2-29-2016	Repeal	4-1-2016
123-052-1100	2-9-2016	Amend(T)	3-1-2016
123-052-1850	2-9-2016	Adopt(T)	3-1-2016
123-200-1000	1-5-2016	Amend	2-1-2016
123-200-1100	1-5-2016	Amend	2-1-2016
123-200-1200	1-5-2016	Repeal	2-1-2016
123-200-1210	1-5-2016	Adopt	2-1-2016
123-200-1220	1-5-2016	Adopt	2-1-2016
123-200-1230	1-5-2016	Adopt	2-1-2016
123-200-1240	1-5-2016	Adopt	2-1-2016
123-200-1300	1-5-2016	Amend	2-1-2016
123-200-1400	1-5-2016	Amend	2-1-2016
123-200-1500	1-5-2016	Amend	2-1-2016
123-200-1600	1-5-2016	Amend	2-1-2016
123-200-1700	1-5-2016	Amend	2-1-2016
123-200-1800	1-5-2016	Amend	2-1-2016
123-200-1900	1-5-2016	Amend	2-1-2016
123-200-2000	1-5-2016	Amend	2-1-2016
123-200-2100	1-5-2016	Am. & Ren.	2-1-2016
123-200-2200	1-5-2016	Amend	2-1-2016
123-200-2210	1-5-2016	Adopt	2-1-2016
123-623-1000	1-29-2016	Amend	3-1-2016
123-623-1100	1-29-2016	Amend	3-1-2016
123-623-1115	1-29-2016	Adopt	3-1-2016
123-623-1250	1-29-2016	Amend	3-1-2016
123-623-1300	1-29-2016	Amend	3-1-2016
123-623-1400	1-29-2016	Amend	3-1-2016
123-623-1500	1-29-2016	Amend	3-1-2016
123-623-1525	1-29-2016	Amend	3-1-2016
123-623-1600	1-29-2016	Amend	3-1-2016
123-623-1700	1-29-2016	Amend	3-1-2016
123-623-1800	1-29-2016	Amend	3-1-2016
123-623-1900	1-29-2016	Amend	3-1-2016
123-623-1950	1-29-2016	Amend	3-1-2016
123-623-2000	1-29-2016	Amend	3-1-2016
123-623-3000	1-29-2016	Amend	3-1-2016
123-623-3200	1-29-2016	Amend	3-1-2016
123-623-4000	1-29-2016	Amend	3-1-2016
123-623-4100	1-29-2016	Amend	3-1-2016
123-623-4200	1-29-2016	Adopt	3-1-2016
123-635-0000	3-28-2016	Amend	5-1-2016
123-635-0100	3-28-2016	Amend	5-1-2016
123-635-0150	3-28-2016	Amend	5-1-2016
123-635-0175	3-28-2016	Amend	5-1-2016
123-635-0200	3-28-2016	Amend	5-1-2016
123-635-0250	3-28-2016	Amend	5-1-2016
123-635-0270	3-28-2016	Amend	5-1-2016
123-635-0300	3-28-2016	Amend	5-1-2016
123-635-0350	3-28-2016	Amend	5-1-2016
125-007-0200	1-4-2016	Amend	2-1-2016
125-007-0210	1-4-2016	Amend	2-1-2016
125-007-0220	1-4-2016	Amend	2-1-2016
125-007-0230	1-4-2016	Repeal	2-1-2016
125-007-0240	1-4-2016	Repeal	2-1-2016
125-007-0250	1-4-2016	Amend	2-1-2016
125-007-0260	1-4-2016	Amend	2-1-2016
125-007-0270	1-4-2016	Amend	2-1-2016
125-007-0280	1-4-2016	Repeal	2-1-2016
125-007-0290	1-4-2016	Repeal	2-1-2016
125-007-0300	1-4-2016	Amend	2-1-2016
125-007-0310	1-4-2016	Amend	2-1-2016
125-007-0320	1-4-2016	Repeal	2-1-2016
125-007-0330	1-4-2016	Amend	2-1-2016
125-045-0200	1-7-2016	Amend	2-1-2016
125-045-0205	1-7-2016	Amend	2-1-2016
125-045-0225	1-7-2016	Amend	2-1-2016
125-045-0235	1-7-2016	Amend	2-1-2016
125-045-0245	1-7-2016	Amend	2-1-2016
125-055-0040	1-1-2016	Amend	2-1-2016
125-246-0100	1-1-2016	Amend	2-1-2016
125-246-0110	1-1-2016	Amend	2-1-2016
125-246-0135	1-1-2016	Adopt	2-1-2016
125-246-0330	1-1-2016	Amend	2-1-2016
125-246-0500	1-1-2016	Amend	2-1-2016
125-247-0100	1-1-2016	Amend	2-1-2016
125-247-0185	1-1-2016	Adopt	2-1-2016
125-247-0260	1-1-2016	Amend	2-1-2016
125-247-0270	1-1-2016	Amend	2-1-2016
125-247-0500	1-1-2016	Amend	2-1-2016
125-247-0640	1-1-2016	Amend	2-1-2016
125-248-0100	1-1-2016	Amend	2-1-2016
125-248-0220	1-1-2016	Amend	2-1-2016
125-249-0100	1-1-2016	Amend	2-1-2016
125-249-0120	1-1-2016	Amend	2-1-2016
125-249-0370	1-1-2016	Amend	2-1-2016
125-249-0390	1-1-2016	Amend	2-1-2016
125-249-0440	1-1-2016	Amend	2-1-2016
137-003-0640	2-1-2016	Amend	3-1-2016
137-020-0020	1-1-2016	Amend	2-1-2016
137-020-0050	1-1-2016	Amend	2-1-2016
137-046-0110	1-1-2016	Amend	2-1-2016
137-046-0140	1-1-2016	Adopt	2-1-2016
137-046-0200	1-1-2016	Amend	2-1-2016
137-046-0210	1-1-2016	Amend	2-1-2016
137-047-0260	1-1-2016	Amend	2-1-2016
137-047-0640	1-1-2016	Amend	2-1-2016
137-048-0220	1-1-2016	Amend	2-1-2016
137-049-0120	1-1-2016	Amend	2-1-2016
137-049-0370	1-1-2016	Amend	2-1-2016
137-049-0390	1-1-2016	Amend	2-1-2016
137-049-0440	1-1-2016	Amend	2-1-2016
137-050-0715	7-1-2016	Amend	8-1-2016
137-050-0735	1-29-2016	Amend(T)	3-1-2016
137-050-0735	4-1-2016	Amend	5-1-2016
137-050-0745	1-1-2016	Amend	2-1-2016
137-050-0750	7-1-2016	Amend	8-1-2016
137-055-1140	2-1-2016	Amend	3-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
137-055-1160	2-1-2016	Amend	3-1-2016
137-055-3240	1-1-2016	Amend	2-1-2016
137-055-3300	2-1-2016	Amend	3-1-2016
137-055-3490	1-1-2016	Amend	2-1-2016
137-055-3660	1-1-2016	Amend	2-1-2016
137-055-5035	1-1-2016	Amend	2-1-2016
137-055-5080	1-1-2016	Amend	2-1-2016
137-055-5110	2-1-2016	Amend	3-1-2016
137-055-6220	1-1-2016	Amend	2-1-2016
137-055-6240	1-1-2016	Amend	2-1-2016
137-055-7020	1-1-2016	Repeal	2-1-2016
137-055-7040	1-1-2016	Amend	2-1-2016
137-055-7060	1-1-2016	Amend	2-1-2016
137-055-7100	1-1-2016	Amend	2-1-2016
137-055-7120	1-1-2016	Amend	2-1-2016
137-055-7140	1-1-2016	Amend	2-1-2016
137-055-7160	1-1-2016	Amend	2-1-2016
137-055-7160	1-1-2016	Repeal	2-1-2016
137-055-7180	1-1-2016	Amend	2-1-2016
137-055-7190	1-1-2016	Amend	2-1-2016
137-084-0001	4-19-2016	Amend(T)	6-1-2016
137-084-0010	4-19-2016	Amend(T)	6-1-2016
137-084-0020	4-19-2016	Amend(T)	6-1-2016
137-084-0030	4-19-2016	Amend(T)	6-1-2016
137-085-0060	2-3-2016	Adopt	3-1-2016
137-085-0070	2-3-2016	Adopt	3-1-2016
137-085-0080	2-3-2016	Adopt	3-1-2016
137-085-0090	2-3-2016	Adopt	3-1-2016
137-105-0025	5-23-2016	Adopt(T)	7-1-2016
141-067-0130	6-1-2016	Amend	6-1-2016
141-067-0150	6-1-2016	Amend	6-1-2016
141-067-0155	6-1-2016	Amend	6-1-2016
141-067-0170	6-1-2016	Amend	6-1-2016
141-067-0180	6-1-2016	Amend	6-1-2016
141-067-0195	6-1-2016	Amend	6-1-2016
141-067-0200	6-1-2016	Repeal	6-1-2016
141-067-0215	6-1-2016	Amend	6-1-2016
141-067-0220	6-1-2016	Amend	6-1-2016
141-067-0270	6-1-2016	Amend	6-1-2016
141-067-0300	6-1-2016	Amend	6-1-2016
141-068-0000	6-1-2016	Adopt	6-1-2016
141-068-0010	6-1-2016	Adopt	6-1-2016
141-068-0020	6-1-2016	Adopt	6-1-2016
141-068-0030	6-1-2016	Adopt	6-1-2016
141-068-0040	6-1-2016	Adopt	6-1-2016
141-068-0050	6-1-2016	Adopt	6-1-2016
141-068-0060	6-1-2016	Adopt	6-1-2016
141-068-0070	6-1-2016	Adopt	6-1-2016
141-068-0080	6-1-2016	Adopt	6-1-2016
141-068-0090	6-1-2016	Adopt	6-1-2016
141-068-0100	6-1-2016	Adopt	6-1-2016
141-068-0110	6-1-2016	Adopt	6-1-2016
141-068-0120	6-1-2016	Adopt	6-1-2016
141-068-0130	6-1-2016	Adopt	6-1-2016
141-068-0140	6-1-2016	Adopt	6-1-2016
141-089-0820	1-2-2016	Amend(T)	2-1-2016
141-089-0820	6-15-2016	Amend	7-1-2016
141-089-0825	1-2-2016	Amend(T)	2-1-2016
141-089-0825	6-15-2016	Amend	7-1-2016
141-089-0835	1-2-2016	Amend(T)	2-1-2016
141-089-0835	6-15-2016	Amend	7-1-2016
141-093-0185	2-8-2016	Amend	3-1-2016
141-093-0190	2-8-2016	Amend	3-1-2016
141-093-0250	9-1-2016	Adopt	8-1-2016
141-093-0255	9-1-2016	Adopt	8-1-2016
141-093-0260	9-1-2016	Adopt	8-1-2016
141-093-0265	9-1-2016	Adopt	8-1-2016
141-093-0270	9-1-2016	Adopt	8-1-2016
141-093-0275	9-1-2016	Adopt	8-1-2016
141-093-0280	9-1-2016	Adopt	8-1-2016
141-125-0170	12-29-2015	Amend	2-1-2016
150-118.140	1-1-2016	Amend	2-1-2016
150-118.NOTE	1-1-2016	Repeal	2-1-2016
150-183.330(1)	1-1-2016	Am. & Ren.	2-1-2016
150-192.440	1-1-2016	Amend	2-1-2016
150-285C.420-(A)	1-1-2016	Adopt	2-1-2016
150-294.175(1)(c)	1-1-2016	Am. & Ren.	2-1-2016
150-294.175(2)	1-1-2016	Am. & Ren.	2-1-2016
150-305.100-(C)	1-1-2016	Repeal	2-1-2016
150-305.100-(E)	7-1-2016	Adopt	8-1-2016
150-305.120	1-1-2016	Adopt	2-1-2016
150-305.145(5)	1-1-2016	Renumber	2-1-2016
150-305.155-(A)	1-1-2016	Adopt	2-1-2016
150-305.612	1-1-2016	Amend	2-1-2016
150-305.792	12-7-2015	Adopt(T)	1-1-2016
150-306.125	1-1-2016	Repeal	2-1-2016
150-306.126(1)	1-1-2016	Am. & Ren.	2-1-2016
150-306.126(2)	1-1-2016	Am. & Ren.	2-1-2016
150-306.126(3)-(A)	1-1-2016	Am. & Ren.	2-1-2016
150-307.242(2)	1-1-2016	Am. & Ren.	2-1-2016
150-307.405(3)	1-1-2016	Repeal	2-1-2016
150-308.010	1-1-2016	Amend	2-1-2016
150-308.205-(A)	1-1-2016	Amend	2-1-2016
150-308.205-(D)	1-1-2016	Amend	2-1-2016
150-308.205(2)	1-1-2016	Am. & Ren.	2-1-2016
150-308.290-(A)	1-1-2016	Repeal	2-1-2016
150-308.290-(B)	1-1-2016	Amend	2-1-2016
150-309.026(2)-(A)	1-1-2016	Am. & Ren.	2-1-2016
150-309.110-(A)	1-1-2016	Amend	2-1-2016
150-310.110(1)	1-1-2016	Repeal	2-1-2016
150-311.234	1-1-2016	Amend	2-1-2016
150-314.280-(O)	1-1-2016	Adopt	2-1-2016
150-314.280-(O)	1-26-2016	Amend(T)	3-1-2016
150-314.280-(O)	7-1-2016	Amend	8-1-2016
150-314.297(6)	1-1-2016	Am. & Ren.	2-1-2016
150-314.380(2)(B)	1-1-2016	Am. & Ren.	2-1-2016
150-314.400(1)	1-1-2016	Am. & Ren.	2-1-2016
150-314.402	1-1-2016	Repeal	2-1-2016
150-314.402(1)	1-1-2016	Am. & Ren.	2-1-2016
150-314.402(6)	1-1-2016	Am. & Ren.	2-1-2016
150-314.415(2)(f)-(B)	1-1-2016	Amend	2-1-2016
150-314.515(2)	1-1-2016	Am. & Ren.	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
150-314.665(1)-(A)	1-1-2016	Amend	2-1-2016
150-314.665(2)-(C)	1-1-2016	Repeal	2-1-2016
150-314.670-(A)	7-1-2016	Renumber	8-1-2016
150-315.144	1-1-2016	Amend	2-1-2016
150-315.521	1-1-2016	Repeal	2-1-2016
150-316.583(2)	1-1-2016	Am. & Ren.	2-1-2016
150-317.152	1-1-2016	Adopt	2-1-2016
150-317.717	1-1-2016	Adopt	2-1-2016
150-321.207(1)	1-1-2016	Am. & Ren.	2-1-2016
150-358.505	1-1-2016	Amend	2-1-2016
150-401.794	1-1-2016	Renumber	2-1-2016
150-475B.705	6-2-2016	Adopt(T)	7-1-2016
150-475B.710-(A)	1-4-2016	Adopt(T)	1-1-2016
150-475B.710-(A)	7-1-2016	Adopt	8-1-2016
150-475B.710-(B)	1-4-2016	Adopt(T)	1-1-2016
150-475B.710-(B)	7-1-2016	Adopt	8-1-2016
150-475B.710-(C)	1-4-2016	Adopt(T)	1-1-2016
150-475B.710-(C)	7-1-2016	Adopt	8-1-2016
150-475B.715	7-1-2016	Adopt	8-1-2016
150-475B.720	7-1-2016	Adopt	8-1-2016
150-475B.740	7-1-2016	Adopt	8-1-2016
150-475B.755	7-1-2016	Adopt	8-1-2016
161-002-0000	5-12-2016	Amend	6-1-2016
161-025-0060	5-12-2016	Amend	6-1-2016
165-001-0016	1-1-2016	Amend	2-1-2016
165-001-0016	7-6-2016	Amend	8-1-2016
165-001-0025	1-1-2016	Amend	2-1-2016
165-001-0025	7-6-2016	Amend	8-1-2016
165-001-0034	1-1-2016	Amend	2-1-2016
165-001-0034	7-6-2016	Amend	8-1-2016
165-001-0050	1-1-2016	Amend	2-1-2016
165-001-0050	7-6-2016	Amend	8-1-2016
165-001-0095	1-1-2016	Adopt	2-1-2016
165-001-0095	7-6-2016	Amend	8-1-2016
165-005-0055	1-1-2016	Amend	2-1-2016
165-005-0055	7-6-2016	Amend	8-1-2016
165-005-0065	1-1-2016	Amend	2-1-2016
165-005-0065	7-6-2016	Amend	8-1-2016
165-005-0070	1-1-2016	Amend	2-1-2016
165-005-0070	7-6-2016	Amend	8-1-2016
165-005-0170	1-1-2016	Adopt	2-1-2016
165-005-0170	5-13-2016	Amend	6-1-2016
165-007-0030	12-11-2015	Amend	1-1-2016
165-007-0035	1-1-2016	Amend	2-1-2016
165-007-0035	7-6-2016	Amend	8-1-2016
165-010-0005	1-1-2016	Amend	2-1-2016
165-010-0005	7-6-2016	Amend	8-1-2016
165-012-0005	1-1-2016	Amend	2-1-2016
165-012-0005	7-6-2016	Amend	8-1-2016
165-012-0240	1-1-2016	Amend	2-1-2016
165-012-0240	7-6-2016	Amend	8-1-2016
165-013-0010	1-1-2016	Amend	2-1-2016
165-013-0010	7-6-2016	Amend	8-1-2016
165-013-0020	1-1-2016	Amend	2-1-2016
165-013-0020	7-6-2016	Amend	8-1-2016
165-013-0030	1-2-2016	Amend	2-1-2016
165-013-0030	7-6-2016	Amend	8-1-2016
165-014-0005	1-1-2016	Amend	2-1-2016
165-014-0005	7-6-2016	Amend	8-1-2016
165-014-0100	1-1-2016	Amend	2-1-2016
165-014-0100	7-6-2016	Amend	8-1-2016
165-014-0260	1-1-2016	Amend	2-1-2016
165-014-0260	7-6-2016	Amend	8-1-2016
165-014-0280	1-1-2016	Repeal	2-1-2016
165-014-0280	7-6-2016	Repeal	8-1-2016
165-016-0000	1-1-2016	Amend	2-1-2016
165-016-0000	7-6-2016	Amend	8-1-2016
166-017-0005	5-5-2016	Adopt	6-1-2016
166-017-0010	5-5-2016	Amend	6-1-2016
166-017-0015	5-5-2016	Adopt	6-1-2016
166-017-0020	5-5-2016	Repeal	6-1-2016
166-017-0025	5-5-2016	Adopt	6-1-2016
166-017-0030	5-5-2016	Repeal	6-1-2016
166-017-0035	5-5-2016	Adopt	6-1-2016
166-017-0040	5-5-2016	Repeal	6-1-2016
166-017-0045	5-5-2016	Adopt	6-1-2016
166-017-0050	5-5-2016	Repeal	6-1-2016
166-017-0055	5-5-2016	Adopt	6-1-2016
166-017-0060	5-5-2016	Repeal	6-1-2016
166-017-0065	5-5-2016	Adopt	6-1-2016
166-017-0070	5-5-2016	Repeal	6-1-2016
166-017-0075	5-5-2016	Adopt	6-1-2016
166-017-0080	5-5-2016	Repeal	6-1-2016
166-017-0085	5-5-2016	Adopt	6-1-2016
166-017-0090	5-5-2016	Adopt	6-1-2016
166-017-0095	5-5-2016	Adopt	6-1-2016
166-030-0019	5-5-2016	Adopt	6-1-2016
170-062-0000	2-10-2016	Amend	3-1-2016
170-062-0000	6-30-2016	Amend	8-1-2016
170-063-0000	2-12-2016	Amend(T)	3-1-2016
170-063-0000	5-25-2016	Amend	7-1-2016
177-010-0094	1-1-2016	Adopt	2-1-2016
177-040-0003	4-1-2016	Amend(T)	5-1-2016
177-052-0020	6-7-2016	Amend	7-1-2016
177-052-0030	6-7-2016	Amend	7-1-2016
177-052-0040	6-7-2016	Amend	7-1-2016
177-052-0050	6-7-2016	Amend	7-1-2016
177-052-0060	6-7-2016	Amend	7-1-2016
177-052-0070	6-7-2016	Amend	7-1-2016
177-070-0080	2-22-2016	Amend(T)	4-1-2016
177-094-0080	8-9-2016	Amend(T)	8-1-2016
199-001-0010	6-1-2016	Amend	7-1-2016
199-001-0030	6-1-2016	Amend	7-1-2016
199-040-0020	6-1-2016	Adopt	7-1-2016
199-040-0025	6-1-2016	Adopt	7-1-2016
199-040-0030	6-1-2016	Adopt	7-1-2016
199-040-0050	6-1-2016	Adopt	7-1-2016
213-003-0001	5-10-2016	Amend	6-1-2016
213-017-0002	5-10-2016	Amend	6-1-2016
213-017-0003	5-10-2016	Amend	6-1-2016
213-017-0005	5-10-2016	Amend	6-1-2016
213-017-0006	5-10-2016	Amend	6-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
213-017-0007	5-10-2016	Amend	6-1-2016
213-017-0008	5-10-2016	Amend	6-1-2016
213-018-0035	5-10-2016	Amend	6-1-2016
213-018-0050	5-10-2016	Amend	6-1-2016
213-018-0068	5-10-2016	Amend	6-1-2016
250-001-0035	5-12-2016	Adopt(T)	6-1-2016
250-010-0057	4-13-2016	Suspend	5-1-2016
250-010-0057(T)	7-1-2016	Repeal	8-1-2016
250-010-0058	7-1-2016	Amend	8-1-2016
250-011-0050	5-2-2016	Amend(T)	6-1-2016
250-011-0050	7-1-2016	Amend	8-1-2016
250-011-0050(T)	7-1-2016	Repeal	8-1-2016
250-011-0060	5-2-2016	Amend(T)	6-1-2016
250-011-0060	7-1-2016	Amend	8-1-2016
250-011-0060(T)	7-1-2016	Repeal	8-1-2016
250-020-0032	6-7-2016	Amend(T)	7-1-2016
250-020-0161	7-1-2016	Amend	8-1-2016
250-020-0221	4-1-2016	Amend(T)	5-1-2016
250-020-0340	7-1-2016	Amend	8-1-2016
250-030-0010	2-1-2016	Repeal	2-1-2016
250-030-0020	2-1-2016	Repeal	2-1-2016
250-030-0030	2-1-2016	Repeal	2-1-2016
250-030-0041	2-1-2016	Repeal	2-1-2016
250-030-0100	2-1-2016	Adopt	2-1-2016
250-030-0110	2-1-2016	Adopt	2-1-2016
250-030-0120	2-1-2016	Adopt	2-1-2016
250-030-0130	2-1-2016	Adopt	2-1-2016
250-030-0140	2-1-2016	Adopt	2-1-2016
250-030-0150	2-1-2016	Adopt	2-1-2016
250-030-0160	2-1-2016	Adopt	2-1-2016
250-030-0170	2-1-2016	Adopt	2-1-2016
250-030-0180	2-1-2016	Adopt	2-1-2016
255-030-0015	4-26-2016	Amend(T)	6-1-2016
255-085-0010	1-27-2016	Adopt	3-1-2016
255-085-0020	1-27-2016	Adopt	3-1-2016
255-085-0030	1-27-2016	Adopt	3-1-2016
255-085-0040	1-27-2016	Adopt	3-1-2016
255-085-0050	1-27-2016	Adopt	3-1-2016
257-070-0010	3-7-2016	Repeal	4-1-2016
257-070-0015	3-7-2016	Amend	4-1-2016
257-070-0100	3-7-2016	Adopt	4-1-2016
257-070-0110	3-7-2016	Adopt	4-1-2016
257-070-0120	3-7-2016	Adopt	4-1-2016
257-070-0130	3-7-2016	Adopt	4-1-2016
259-008-0005	1-1-2016	Amend	2-1-2016
259-008-0005	4-1-2016	Amend	5-1-2016
259-008-0010	1-1-2016	Amend	2-1-2016
259-008-0010	4-1-2016	Amend	5-1-2016
259-008-0011	4-1-2016	Amend	5-1-2016
259-008-0015	4-1-2016	Amend	5-1-2016
259-008-0020	4-1-2016	Amend	5-1-2016
259-008-0025	1-1-2016	Amend	2-1-2016
259-008-0025	3-22-2016	Amend	5-1-2016
259-008-0030	3-22-2016	Repeal	5-1-2016
259-008-0035	3-22-2016	Repeal	5-1-2016
259-008-0040	1-1-2016	Amend	2-1-2016
259-008-0060	1-1-2016	Amend	2-1-2016
259-008-0085	3-22-2016	Amend	5-1-2016
259-008-0100	1-1-2016	Amend	2-1-2016
259-009-0059	1-1-2016	Amend	2-1-2016
259-009-0062	12-22-2015	Amend	2-1-2016
259-009-0070	1-1-2016	Amend	2-1-2016
259-060-0010	12-22-2015	Amend	2-1-2016
259-060-0010	6-22-2016	Amend	8-1-2016
259-060-0015	12-22-2015	Amend	2-1-2016
259-060-0015	6-22-2016	Amend	8-1-2016
259-060-0025	6-22-2016	Amend	8-1-2016
259-060-0030	6-22-2016	Amend	8-1-2016
259-060-0060	3-22-2016	Amend	5-1-2016
259-060-0120	3-22-2016	Amend	5-1-2016
259-060-0130	6-22-2016	Amend	8-1-2016
259-060-0135	3-22-2016	Amend	5-1-2016
259-060-0145	12-22-2015	Amend	2-1-2016
259-061-0010	3-22-2016	Amend	5-1-2016
259-061-0018	3-22-2016	Amend	5-1-2016
259-061-0120	12-22-2015	Amend	2-1-2016
259-061-0160	3-22-2016	Amend	5-1-2016
259-061-0170	3-22-2016	Repeal	5-1-2016
259-061-0250	3-22-2016	Repeal	5-1-2016
259-061-0300	3-22-2016	Amend	5-1-2016
274-005-0040	12-28-2015	Amend	2-1-2016
274-005-0046	12-28-2015	Adopt	2-1-2016
291-014-0110	4-29-2016	Amend	6-1-2016
291-014-0120	4-29-2016	Amend	6-1-2016
291-041-0010	3-24-2016	Amend	5-1-2016
291-041-0015	3-24-2016	Amend	5-1-2016
291-041-0016	3-24-2016	Amend	5-1-2016
291-041-0018	3-24-2016	Amend	5-1-2016
291-041-0020	3-24-2016	Amend	5-1-2016
291-041-0030	3-24-2016	Amend	5-1-2016
291-041-0035	3-24-2016	Amend	5-1-2016
291-082-0110	3-8-2016	Amend	4-1-2016
291-131-0005	5-10-2016	Amend	6-1-2016
291-131-0010	5-10-2016	Amend	6-1-2016
291-131-0015	5-10-2016	Amend	6-1-2016
291-131-0020	5-10-2016	Amend	6-1-2016
291-131-0021	5-10-2016	Amend	6-1-2016
291-131-0025	5-10-2016	Amend	6-1-2016
291-131-0026	5-10-2016	Adopt	6-1-2016
291-131-0030	5-10-2016	Amend	6-1-2016
291-131-0035	5-10-2016	Amend	6-1-2016
291-131-0037	5-10-2016	Amend	6-1-2016
291-131-0050	5-10-2016	Amend	6-1-2016
291-133-0005	4-20-2016	Amend	6-1-2016
291-133-0015	4-20-2016	Amend	6-1-2016
291-133-0025	4-20-2016	Amend	6-1-2016
291-133-0035	4-20-2016	Amend	6-1-2016
291-167-0005	2-29-2016	Amend	4-1-2016
291-167-0010	2-29-2016	Amend	4-1-2016
291-167-0015	2-29-2016	Amend	4-1-2016
291-180-0252	3-1-2016	Amend	4-1-2016
291-205-0020	1-21-2016	Amend	3-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
291-205-0030	1-21-2016	Amend	3-1-2016
291-205-0050	1-21-2016	Amend	3-1-2016
291-209-0010	1-1-2016	Amend(T)	2-1-2016
291-209-0010	3-30-2016	Amend	5-1-2016
291-209-0010(T)	3-30-2016	Repeal	5-1-2016
291-209-0020	1-1-2016	Amend(T)	2-1-2016
291-209-0020	3-30-2016	Amend	5-1-2016
291-209-0020(T)	3-30-2016	Repeal	5-1-2016
291-209-0030	1-1-2016	Amend(T)	2-1-2016
291-209-0030	3-30-2016	Amend	5-1-2016
291-209-0030(T)	3-30-2016	Repeal	5-1-2016
291-209-0040	1-1-2016	Amend(T)	2-1-2016
291-209-0040	3-30-2016	Amend	5-1-2016
291-209-0040(T)	3-30-2016	Repeal	5-1-2016
291-209-0050	1-1-2016	Suspend	2-1-2016
291-209-0050	3-30-2016	Repeal	5-1-2016
291-209-0050(T)	3-30-2016	Repeal	5-1-2016
291-209-0060	1-1-2016	Suspend	2-1-2016
291-209-0060	3-30-2016	Repeal	5-1-2016
291-209-0060(T)	3-30-2016	Repeal	5-1-2016
291-209-0070	1-1-2016	Amend(T)	2-1-2016
309-008-0100	7-1-2016	Adopt(T)	8-1-2016
309-008-0200	7-1-2016	Adopt(T)	8-1-2016
309-008-0250	7-1-2016	Adopt(T)	8-1-2016
309-008-0300	7-1-2016	Adopt(T)	8-1-2016
309-008-0400	7-1-2016	Adopt(T)	8-1-2016
309-008-0500	7-1-2016	Adopt(T)	8-1-2016
309-008-0600	7-1-2016	Adopt(T)	8-1-2016
309-008-0700	7-1-2016	Adopt(T)	8-1-2016
309-008-0800	7-1-2016	Adopt(T)	8-1-2016
309-008-0900	7-1-2016	Adopt(T)	8-1-2016
309-008-1000	7-1-2016	Adopt(T)	8-1-2016
309-008-1100	7-1-2016	Adopt(T)	8-1-2016
309-008-1200	7-1-2016	Adopt(T)	8-1-2016
309-008-1300	7-1-2016	Adopt(T)	8-1-2016
309-008-1400	7-1-2016	Adopt(T)	8-1-2016
309-008-1500	7-1-2016	Adopt(T)	8-1-2016
309-008-1600	7-1-2016	Adopt(T)	8-1-2016
309-012-0130	11-25-2015	Amend(T)	1-1-2016
309-012-0130(T)	7-1-2016	Suspend	8-1-2016
309-012-0140(T)	7-1-2016	Suspend	8-1-2016
309-012-0150(T)	7-1-2016	Suspend	8-1-2016
309-012-0160(T)	7-1-2016	Suspend	8-1-2016
309-012-0170(T)	7-1-2016	Suspend	8-1-2016
309-012-0180(T)	7-1-2016	Suspend	8-1-2016
309-012-0190(T)	7-1-2016	Suspend	8-1-2016
309-012-0200(T)	7-1-2016	Suspend	8-1-2016
309-012-0210	11-25-2015	Amend(T)	1-1-2016
309-012-0210(T)	7-1-2016	Suspend	8-1-2016
309-012-0220	11-25-2015	Amend(T)	1-1-2016
309-012-0220(T)	7-1-2016	Suspend	8-1-2016
309-012-0230	7-1-2016	Suspend	8-1-2016
309-018-0100	7-1-2016	Amend(T)	8-1-2016
309-018-0105	7-1-2016	Amend(T)	8-1-2016
309-018-0107	7-1-2016	Adopt(T)	8-1-2016
309-018-0160	7-1-2016	Amend(T)	8-1-2016
309-018-0210	7-1-2016	Amend(T)	8-1-2016
309-018-0215	7-1-2016	Amend(T)	8-1-2016
309-019-0100	7-1-2016	Amend(T)	8-1-2016
309-019-0105	7-1-2016	Amend(T)	8-1-2016
309-019-0110	7-1-2016	Amend(T)	8-1-2016
309-019-0125	7-1-2016	Amend(T)	8-1-2016
309-019-0130	7-1-2016	Amend(T)	8-1-2016
309-019-0140	7-1-2016	Amend(T)	8-1-2016
309-019-0145	7-1-2016	Amend(T)	8-1-2016
309-019-0195	7-1-2016	Amend(T)	8-1-2016
309-019-0215	7-1-2016	Amend(T)	8-1-2016
309-019-0220	7-1-2016	Amend(T)	8-1-2016
309-019-0225	7-1-2016	Adopt(T)	8-1-2016
309-019-0230	7-1-2016	Adopt(T)	8-1-2016
309-019-0235	7-1-2016	Adopt(T)	8-1-2016
309-019-0240	7-1-2016	Adopt(T)	8-1-2016
309-019-0245	7-1-2016	Adopt(T)	8-1-2016
309-019-0248	7-1-2016	Adopt(T)	8-1-2016
309-019-0250	7-1-2016	Adopt(T)	8-1-2016
309-019-0255	7-1-2016	Adopt(T)	8-1-2016
309-022-0100	7-1-2016	Amend(T)	8-1-2016
309-022-0105	7-1-2016	Amend(T)	8-1-2016
309-022-0135	7-1-2016	Amend(T)	8-1-2016
309-022-0175	7-1-2016	Amend(T)	8-1-2016
309-022-0205	7-1-2016	Amend(T)	8-1-2016
309-039-0500	7-1-2016	Amend(T)	8-1-2016
309-039-0510	7-1-2016	Amend(T)	8-1-2016
309-039-0530	7-1-2016	Amend(T)	8-1-2016
309-039-0580	7-1-2016	Amend(T)	8-1-2016
309-088-0100	4-7-2016	Adopt(T)	5-1-2016
309-088-0110	4-7-2016	Adopt(T)	5-1-2016
309-088-0120	4-7-2016	Adopt(T)	5-1-2016
309-090-0000	5-3-2016	Amend	6-1-2016
309-090-0005	5-3-2016	Amend	6-1-2016
309-090-0010	5-3-2016	Amend	6-1-2016
309-090-0015	5-3-2016	Amend	6-1-2016
309-090-0020	5-3-2016	Amend	6-1-2016
309-090-0025	5-3-2016	Amend	6-1-2016
309-090-0030	5-3-2016	Amend	6-1-2016
309-090-0035	5-3-2016	Amend	6-1-2016
309-090-0050	5-3-2016	Amend	6-1-2016
309-090-0055	5-3-2016	Amend	6-1-2016
309-090-0060	5-3-2016	Amend	6-1-2016
309-090-0065	5-3-2016	Amend	6-1-2016
309-090-0070	5-3-2016	Amend	6-1-2016
309-091-0050	4-28-2016	Amend	6-1-2016
309-112-0000	4-21-2016	Amend	6-1-2016
309-112-0005	4-21-2016	Amend	6-1-2016
309-112-0010	4-21-2016	Amend	6-1-2016
309-112-0015	4-21-2016	Amend	6-1-2016
309-112-0017	4-21-2016	Amend	6-1-2016
309-112-0020	4-21-2016	Amend	6-1-2016
309-112-0025	4-21-2016	Amend	6-1-2016
309-112-0030	4-21-2016	Amend	6-1-2016
309-112-0035	4-21-2016	Amend	6-1-2016
309-114-0000	5-25-2016	Amend	7-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
309-114-0005	11-24-2015	Amend(T)	1-1-2016
309-114-0005	5-25-2016	Amend	7-1-2016
325-005-0015	1-29-2016	Amend	3-1-2016
325-010-0025	1-29-2016	Amend	3-1-2016
330-070-0022	6-2-2016	Amend	7-1-2016
330-135-0055	1-1-2016	Amend	2-1-2016
330-140-0020	12-23-2015	Amend	2-1-2016
330-140-0060	12-23-2015	Amend	2-1-2016
330-140-0070	12-23-2015	Amend	2-1-2016
330-140-0140	12-23-2015	Amend	2-1-2016
330-170-0010	3-1-2016	Amend	4-1-2016
330-170-0050	3-1-2016	Amend	4-1-2016
330-210-0000	3-15-2016	Amend	4-1-2016
330-210-0010	3-15-2016	Amend	4-1-2016
330-210-0040	3-15-2016	Amend	4-1-2016
330-210-0100	3-15-2016	Amend	4-1-2016
330-210-0110	3-15-2016	Adopt	4-1-2016
330-210-0150	3-15-2016	Amend	4-1-2016
331-130-0011	7-1-2016	Amend	8-1-2016
331-710-0050	1-1-2016	Amend	2-1-2016
331-715-0010	7-1-2016	Amend	8-1-2016
333-002-0000	7-1-2016	Amend	7-1-2016
333-002-0010	7-1-2016	Amend	7-1-2016
333-002-0020	7-1-2016	Amend	7-1-2016
333-002-0030	7-1-2016	Amend	7-1-2016
333-002-0035	7-1-2016	Amend	7-1-2016
333-002-0040	7-1-2016	Amend	7-1-2016
333-002-0050	7-1-2016	Amend	7-1-2016
333-002-0060	7-1-2016	Amend	7-1-2016
333-002-0070	7-1-2016	Amend	7-1-2016
333-002-0080	7-1-2016	Amend	7-1-2016
333-002-0100	7-1-2016	Repeal	7-1-2016
333-002-0120	7-1-2016	Amend	7-1-2016
333-002-0130	7-1-2016	Repeal	7-1-2016
333-002-0140	7-1-2016	Amend	7-1-2016
333-002-0150	7-1-2016	Amend	7-1-2016
333-002-0160	7-1-2016	Repeal	7-1-2016
333-002-0170	7-1-2016	Amend	7-1-2016
333-002-0180	7-1-2016	Repeal	7-1-2016
333-002-0190	7-1-2016	Amend	7-1-2016
333-002-0200	7-1-2016	Repeal	7-1-2016
333-002-0210	7-1-2016	Amend	7-1-2016
333-002-0220	7-1-2016	Repeal	7-1-2016
333-002-0230	7-1-2016	Amend	7-1-2016
333-007-0010	2-8-2016	Amend(T)	3-1-2016
333-007-0010	6-28-2016	Amend	8-1-2016
333-007-0010(T)	6-28-2016	Repeal	8-1-2016
333-007-0020	6-28-2016	Amend	8-1-2016
333-007-0020(T)	6-28-2016	Repeal	8-1-2016
333-007-0030	6-28-2016	Amend	8-1-2016
333-007-0030(T)	6-28-2016	Repeal	8-1-2016
333-007-0040	6-28-2016	Amend	8-1-2016
333-007-0040(T)	6-28-2016	Repeal	8-1-2016
333-007-0050	6-28-2016	Amend	8-1-2016
333-007-0050(T)	6-28-2016	Repeal	8-1-2016
333-007-0060	6-28-2016	Amend	8-1-2016
333-007-0060(T)	6-28-2016	Repeal	8-1-2016
333-007-0070	6-28-2016	Amend	8-1-2016
333-007-0070(T)	6-28-2016	Repeal	8-1-2016
333-007-0080	6-28-2016	Amend	8-1-2016
333-007-0080(T)	6-28-2016	Repeal	8-1-2016
333-007-0083	6-28-2016	Amend	8-1-2016
333-007-0083(T)	6-28-2016	Repeal	8-1-2016
333-007-0085	6-28-2016	Amend	8-1-2016
333-007-0085(T)	6-28-2016	Repeal	8-1-2016
333-007-0090	6-28-2016	Amend	8-1-2016
333-007-0090(T)	6-28-2016	Repeal	8-1-2016
333-007-0100	6-28-2016	Amend	8-1-2016
333-007-0100(T)	6-28-2016	Repeal	8-1-2016
333-007-0200	2-8-2016	Amend(T)	3-1-2016
333-007-0200	6-28-2016	Amend	8-1-2016
333-007-0200(T)	6-28-2016	Repeal	8-1-2016
333-007-0210	6-28-2016	Amend	8-1-2016
333-007-0210(T)	6-28-2016	Repeal	8-1-2016
333-007-0220	6-28-2016	Amend	8-1-2016
333-007-0220(T)	6-28-2016	Repeal	8-1-2016
333-007-0300	6-28-2016	Amend	8-1-2016
333-007-0310	6-28-2016	Amend	8-1-2016
333-007-0315	6-28-2016	Amend	8-1-2016
333-007-0315(T)	6-28-2016	Repeal	8-1-2016
333-007-0320	6-28-2016	Amend	8-1-2016
333-007-0320(T)	6-28-2016	Repeal	8-1-2016
333-007-0330	6-28-2016	Amend	8-1-2016
333-007-0330(T)	6-28-2016	Repeal	8-1-2016
333-007-0340	6-28-2016	Amend	8-1-2016
333-007-0340(T)	6-28-2016	Repeal	8-1-2016
333-007-0345	6-28-2016	Adopt	8-1-2016
333-007-0350	6-28-2016	Amend	8-1-2016
333-007-0350(T)	6-28-2016	Repeal	8-1-2016
333-007-0360	6-28-2016	Amend	8-1-2016
333-007-0360(T)	6-28-2016	Repeal	8-1-2016
333-007-0370	6-28-2016	Amend	8-1-2016
333-007-0370(T)	6-28-2016	Repeal	8-1-2016
333-007-0380	6-28-2016	Amend	8-1-2016
333-007-0380(T)	6-28-2016	Repeal	8-1-2016
333-007-0390	6-28-2016	Amend	8-1-2016
333-007-0390(T)	6-28-2016	Repeal	8-1-2016
333-007-0400	6-28-2016	Amend	8-1-2016
333-007-0400(T)	6-28-2016	Repeal	8-1-2016
333-007-0410	6-28-2016	Amend	8-1-2016
333-007-0410(T)	6-28-2016	Repeal	8-1-2016
333-007-0420	6-28-2016	Amend	8-1-2016
333-007-0420(T)	6-28-2016	Repeal	8-1-2016
333-007-0430	6-28-2016	Amend	8-1-2016
333-007-0430(T)	6-28-2016	Repeal	8-1-2016
333-007-0440	6-28-2016	Amend	8-1-2016
333-007-0440(T)	6-28-2016	Repeal	8-1-2016
333-007-0450	6-28-2016	Amend	8-1-2016
333-007-0450(T)	6-28-2016	Repeal	8-1-2016
333-007-0460	6-28-2016	Repeal	8-1-2016
333-007-0470	6-28-2016	Amend	8-1-2016
333-007-0470(T)	6-28-2016	Repeal	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
333-007-0480	6-28-2016	Amend	8-1-2016
333-007-0480(T)	6-28-2016	Repeal	8-1-2016
333-007-0490	6-28-2016	Amend	8-1-2016
333-007-0490(T)	6-28-2016	Repeal	8-1-2016
333-008-0000	3-1-2016	Repeal	4-1-2016
333-008-0010	3-1-2016	Amend	4-1-2016
333-008-0010	6-28-2016	Amend	8-1-2016
333-008-0010(T)	3-1-2016	Repeal	4-1-2016
333-008-0020	3-1-2016	Amend	4-1-2016
333-008-0020	6-28-2016	Amend	8-1-2016
333-008-0021	3-1-2016	Adopt	4-1-2016
333-008-0021	6-28-2016	Amend	8-1-2016
333-008-0022	3-1-2016	Adopt	4-1-2016
333-008-0022	6-28-2016	Amend	8-1-2016
333-008-0023	3-1-2016	Adopt	4-1-2016
333-008-0023	6-28-2016	Amend	8-1-2016
333-008-0025	3-1-2016	Amend	4-1-2016
333-008-0025	6-28-2016	Amend	8-1-2016
333-008-0025(T)	3-1-2016	Repeal	4-1-2016
333-008-0030	3-1-2016	Amend	4-1-2016
333-008-0033	3-1-2016	Adopt	4-1-2016
333-008-0033	6-28-2016	Amend	8-1-2016
333-008-0035	3-1-2016	Adopt	4-1-2016
333-008-0037	3-1-2016	Adopt	4-1-2016
333-008-0037	6-28-2016	Amend	8-1-2016
333-008-0040	3-1-2016	Amend	4-1-2016
333-008-0040	6-28-2016	Amend	8-1-2016
333-008-0045	3-1-2016	Amend	4-1-2016
333-008-0045	6-28-2016	Amend	8-1-2016
333-008-0047	3-1-2016	Adopt	4-1-2016
333-008-0049	3-1-2016	Adopt	4-1-2016
333-008-0050	3-2-2016	Repeal	4-1-2016
333-008-0060	3-1-2016	Repeal	4-1-2016
333-008-0070	3-1-2016	Repeal	4-1-2016
333-008-0080	3-1-2016	Amend	4-1-2016
333-008-0080	6-28-2016	Amend	8-1-2016
333-008-0110	3-1-2016	Amend	4-1-2016
333-008-0120	3-1-2016	Repeal	4-1-2016
333-008-0300(T)	6-28-2016	Repeal	8-1-2016
333-008-0310(T)	6-28-2016	Repeal	8-1-2016
333-008-0499	1-1-2016	Adopt(T)	2-1-2016
333-008-0499(T)	3-1-2016	Repeal	4-1-2016
333-008-0500	1-1-2016	Adopt(T)	2-1-2016
333-008-0500	3-1-2016	Adopt	4-1-2016
333-008-0500	6-28-2016	Amend	8-1-2016
333-008-0500(T)	3-1-2016	Repeal	4-1-2016
333-008-0510	1-1-2016	Adopt(T)	2-1-2016
333-008-0510	3-1-2016	Adopt	4-1-2016
333-008-0510	6-28-2016	Amend	8-1-2016
333-008-0510(T)	3-1-2016	Repeal	4-1-2016
333-008-0520	1-1-2016	Adopt(T)	2-1-2016
333-008-0520	3-1-2016	Adopt	4-1-2016
333-008-0520(T)	3-1-2016	Repeal	4-1-2016
333-008-0530	1-1-2016	Adopt(T)	2-1-2016
333-008-0530	3-1-2016	Adopt	4-1-2016
333-008-0530(T)	3-1-2016	Repeal	4-1-2016
333-008-0540	3-1-2016	Adopt	4-1-2016
333-008-0540	6-28-2016	Amend	8-1-2016
333-008-0550	3-1-2016	Adopt	4-1-2016
333-008-0550	6-28-2016	Amend	8-1-2016
333-008-0560	3-1-2016	Adopt	4-1-2016
333-008-0560	6-28-2016	Amend	8-1-2016
333-008-0570	3-1-2016	Adopt	4-1-2016
333-008-0570	6-28-2016	Amend	8-1-2016
333-008-0580	3-1-2016	Adopt	4-1-2016
333-008-0600	3-1-2016	Adopt	4-1-2016
333-008-0630	3-1-2016	Adopt	4-1-2016
333-008-0630	6-28-2016	Amend	8-1-2016
333-008-0640	3-1-2016	Adopt	4-1-2016
333-008-0700	3-1-2016	Adopt	4-1-2016
333-008-0710	3-1-2016	Adopt	4-1-2016
333-008-0720	3-1-2016	Adopt	4-1-2016
333-008-0730	3-1-2016	Adopt	4-1-2016
333-008-0740	3-1-2016	Adopt	4-1-2016
333-008-0750	3-1-2016	Adopt	4-1-2016
333-008-1000	3-1-2016	Amend	4-1-2016
333-008-1000	6-28-2016	Amend	8-1-2016
333-008-1010	3-1-2016	Amend	4-1-2016
333-008-1010(T)	3-1-2016	Repeal	4-1-2016
333-008-1020	3-1-2016	Amend	4-1-2016
333-008-1020	6-28-2016	Amend	8-1-2016
333-008-1030	3-1-2016	Amend	4-1-2016
333-008-1040	3-1-2016	Amend	4-1-2016
333-008-1040	6-28-2016	Amend	8-1-2016
333-008-1050	3-1-2016	Amend	4-1-2016
333-008-1060	3-1-2016	Amend	4-1-2016
333-008-1060	6-28-2016	Amend	8-1-2016
333-008-1060(T)	3-1-2016	Repeal	4-1-2016
333-008-1063	3-1-2016	Adopt	4-1-2016
333-008-1070	3-1-2016	Amend	4-1-2016
333-008-1070	6-28-2016	Amend	8-1-2016
333-008-1070(T)	3-1-2016	Repeal	4-1-2016
333-008-1073	3-1-2016	Adopt	4-1-2016
333-008-1073	6-28-2016	Repeal	8-1-2016
333-008-1075	3-1-2016	Adopt	4-1-2016
333-008-1075	6-28-2016	Amend	8-1-2016
333-008-1078	3-1-2016	Adopt	4-1-2016
333-008-1078	6-28-2016	Amend	8-1-2016
333-008-1080	3-1-2016	Repeal	4-1-2016
333-008-1090	3-1-2016	Repeal	4-1-2016
333-008-1100	3-1-2016	Repeal	4-1-2016
333-008-1110	3-1-2016	Amend	4-1-2016
333-008-1110	6-28-2016	Amend	8-1-2016
333-008-1120	3-1-2016	Repeal	4-1-2016
333-008-1130	3-2-2016	Repeal	4-1-2016
333-008-1140	3-2-2016	Repeal	4-1-2016
333-008-1150	3-2-2016	Repeal	4-1-2016
333-008-1160	3-2-2016	Repeal	4-1-2016
333-008-1170	3-2-2016	Repeal	4-1-2016
333-008-1180	3-2-2016	Repeal	4-1-2016
333-008-1190	3-1-2016	Amend	4-1-2016
333-008-1190	6-28-2016	Amend	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
333-008-1200	3-1-2016	Amend	4-1-2016
333-008-1200	6-28-2016	Amend	8-1-2016
333-008-1205	3-1-2016	Adopt	4-1-2016
333-008-1205	6-28-2016	Amend	8-1-2016
333-008-1210	3-1-2016	Repeal	4-1-2016
333-008-1220	3-1-2016	Amend	4-1-2016
333-008-1225	3-1-2016	Amend	4-1-2016
333-008-1225	4-15-2016	Amend(T)	5-1-2016
333-008-1225	6-28-2016	Amend	8-1-2016
333-008-1225(T)	6-28-2016	Repeal	8-1-2016
333-008-1230	3-1-2016	Amend	4-1-2016
333-008-1230	6-28-2016	Amend	8-1-2016
333-008-1240	3-1-2016	Repeal	4-1-2016
333-008-1245	3-1-2016	Amend	4-1-2016
333-008-1245	6-28-2016	Amend	8-1-2016
333-008-1247	3-1-2016	Adopt	4-1-2016
333-008-1248	3-1-2016	Adopt	4-1-2016
333-008-1250	3-1-2016	Repeal	4-1-2016
333-008-1260	3-1-2016	Repeal	4-1-2016
333-008-1270	3-1-2016	Repeal	4-1-2016
333-008-1275	3-1-2016	Repeal	4-1-2016
333-008-1280	3-1-2016	Repeal	4-1-2016
333-008-1290	3-1-2016	Repeal	4-1-2016
333-008-1400	3-1-2016	Repeal	4-1-2016
333-008-1500	3-1-2016	Adopt	4-1-2016
333-008-1500	6-2-2016	Amend(T)	7-1-2016
333-008-1500(T)	3-1-2016	Repeal	4-1-2016
333-008-1501	3-1-2016	Adopt	4-1-2016
333-008-1501(T)	3-1-2016	Repeal	4-1-2016
333-008-1505	3-1-2016	Adopt	4-1-2016
333-008-1505	6-2-2016	Amend(T)	7-1-2016
333-008-1600	3-1-2016	Adopt	4-1-2016
333-008-1610	3-1-2016	Adopt	4-1-2016
333-008-1610	6-28-2016	Amend	8-1-2016
333-008-1620	3-1-2016	Adopt	4-1-2016
333-008-1620	6-28-2016	Amend	8-1-2016
333-008-1630	3-1-2016	Adopt	4-1-2016
333-008-1640	3-1-2016	Adopt	4-1-2016
333-008-1640	6-28-2016	Repeal	8-1-2016
333-008-1650	3-1-2016	Adopt	4-1-2016
333-008-1650	6-28-2016	Amend	8-1-2016
333-008-1660	3-1-2016	Adopt	4-1-2016
333-008-1670	3-1-2016	Adopt	4-1-2016
333-008-1670	6-28-2016	Amend	8-1-2016
333-008-1680	3-1-2016	Adopt	4-1-2016
333-008-1690	3-1-2016	Adopt	4-1-2016
333-008-1690	6-28-2016	Amend	8-1-2016
333-008-1700	3-1-2016	Adopt	4-1-2016
333-008-1710	3-1-2016	Adopt	4-1-2016
333-008-1710	6-28-2016	Amend	8-1-2016
333-008-1720	3-1-2016	Adopt	4-1-2016
333-008-1720	6-28-2016	Amend	8-1-2016
333-008-1730	3-1-2016	Adopt	4-1-2016
333-008-1730	6-28-2016	Amend	8-1-2016
333-008-1740	3-1-2016	Adopt	4-1-2016
333-008-1740	6-28-2016	Amend	8-1-2016
333-008-1750	3-1-2016	Adopt	4-1-2016
333-008-1760	3-1-2016	Adopt	4-1-2016
333-008-1760	6-28-2016	Amend	8-1-2016
333-008-1770	3-1-2016	Adopt	4-1-2016
333-008-1770	6-28-2016	Amend	8-1-2016
333-008-1780	3-1-2016	Adopt	4-1-2016
333-008-1780	6-28-2016	Amend	8-1-2016
333-008-1790	3-1-2016	Adopt	4-1-2016
333-008-1790	6-28-2016	Amend	8-1-2016
333-008-1800	3-1-2016	Adopt	4-1-2016
333-008-1800	6-28-2016	Amend	8-1-2016
333-008-1810	3-1-2016	Adopt	4-1-2016
333-008-1810	6-28-2016	Amend	8-1-2016
333-008-1820	3-1-2016	Adopt	4-1-2016
333-008-1830	3-1-2016	Adopt	4-1-2016
333-008-1830	6-28-2016	Amend	8-1-2016
333-008-2000	3-1-2016	Adopt	4-1-2016
333-008-2010	3-1-2016	Adopt	4-1-2016
333-008-2020	3-1-2016	Adopt	4-1-2016
333-008-2030	3-1-2016	Adopt	4-1-2016
333-008-2030	6-28-2016	Amend	8-1-2016
333-008-2040	3-1-2016	Adopt	4-1-2016
333-008-2050	3-1-2016	Adopt	4-1-2016
333-008-2060	3-1-2016	Adopt	4-1-2016
333-008-2070	3-1-2016	Adopt	4-1-2016
333-008-2080	3-1-2016	Adopt	4-1-2016
333-008-2080	6-28-2016	Amend	8-1-2016
333-008-2090	3-1-2016	Adopt	4-1-2016
333-008-2090	6-28-2016	Amend	8-1-2016
333-008-2100	3-1-2016	Adopt	4-1-2016
333-008-2100	6-28-2016	Amend	8-1-2016
333-008-2110	3-1-2016	Adopt	4-1-2016
333-008-2110	6-28-2016	Amend	8-1-2016
333-008-2120	3-1-2016	Adopt	4-1-2016
333-008-2130	3-1-2016	Adopt	4-1-2016
333-008-2140	3-1-2016	Adopt	4-1-2016
333-008-2150	3-1-2016	Adopt	4-1-2016
333-008-2160	3-1-2016	Adopt	4-1-2016
333-008-2170	3-1-2016	Adopt	4-1-2016
333-008-2180	3-1-2016	Adopt	4-1-2016
333-008-2180	6-28-2016	Amend	8-1-2016
333-008-2190	3-1-2016	Adopt	4-1-2016
333-008-2190	6-28-2016	Amend	8-1-2016
333-008-2200	3-1-2016	Adopt	4-1-2016
333-008-3000	3-1-2016	Adopt	4-1-2016
333-008-3010	3-1-2016	Adopt	4-1-2016
333-008-9000	1-1-2016	Adopt(T)	2-1-2016
333-008-9000(T)	3-1-2016	Repeal	4-1-2016
333-008-9900	4-15-2016	Adopt(T)	5-1-2016
333-010-0100	4-1-2016	Amend	5-1-2016
333-010-0100(T)	4-1-2016	Repeal	5-1-2016
333-010-0105	4-1-2016	Amend	5-1-2016
333-010-0105(T)	4-1-2016	Repeal	5-1-2016
333-010-0110	4-1-2016	Amend	5-1-2016
333-010-0110(T)	4-1-2016	Repeal	5-1-2016
333-010-0115	4-1-2016	Amend	5-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
333-010-0115(T)	4-1-2016	Repeal	5-1-2016
333-010-0120	4-1-2016	Amend	5-1-2016
333-010-0120(T)	4-1-2016	Repeal	5-1-2016
333-010-0125	4-1-2016	Amend	5-1-2016
333-010-0130	4-1-2016	Amend	5-1-2016
333-010-0130(T)	4-1-2016	Repeal	5-1-2016
333-010-0135	4-1-2016	Amend	5-1-2016
333-010-0140	4-1-2016	Amend	5-1-2016
333-010-0140(T)	4-1-2016	Repeal	5-1-2016
333-010-0145	4-1-2016	Amend	5-1-2016
333-010-0145(T)	4-1-2016	Repeal	5-1-2016
333-010-0150	4-1-2016	Amend	5-1-2016
333-010-0155	4-1-2016	Amend	5-1-2016
333-010-0160	4-1-2016	Amend	5-1-2016
333-010-0165	4-1-2016	Amend	5-1-2016
333-010-0175	4-1-2016	Amend	5-1-2016
333-010-0180	4-1-2016	Amend	5-1-2016
333-010-0197	4-1-2016	Amend	5-1-2016
333-010-0197(T)	4-1-2016	Repeal	5-1-2016
333-012-0500	1-1-2016	Am. & Ren.	2-1-2016
333-015-0030	1-1-2016	Amend	2-1-2016
333-015-0035	1-1-2016	Amend	2-1-2016
333-015-0040	1-1-2016	Amend	2-1-2016
333-015-0045	1-1-2016	Amend	2-1-2016
333-015-0064	1-1-2016	Amend	2-1-2016
333-015-0068	1-1-2016	Amend	2-1-2016
333-015-0070	1-1-2016	Amend	2-1-2016
333-015-0075	1-1-2016	Amend	2-1-2016
333-015-0078	1-1-2016	Amend	2-1-2016
333-015-0085	1-1-2016	Amend	2-1-2016
333-015-0200	1-1-2016	Adopt(T)	2-1-2016
333-015-0200	6-24-2016	Amend	8-1-2016
333-015-0200(T)	6-24-2016	Repeal	8-1-2016
333-015-0205	1-1-2016	Adopt(T)	2-1-2016
333-015-0205	6-24-2016	Amend	8-1-2016
333-015-0205(T)	6-24-2016	Repeal	8-1-2016
333-015-0210	1-1-2016	Adopt(T)	2-1-2016
333-015-0210	6-24-2016	Amend	8-1-2016
333-015-0210(T)	6-24-2016	Repeal	8-1-2016
333-015-0215	1-1-2016	Adopt(T)	2-1-2016
333-015-0215	6-24-2016	Amend	8-1-2016
333-015-0215(T)	6-24-2016	Repeal	8-1-2016
333-015-0220	1-1-2016	Adopt(T)	2-1-2016
333-015-0220	6-24-2016	Amend	8-1-2016
333-015-0220(T)	6-24-2016	Repeal	8-1-2016
333-015-0300	6-24-2016	Adopt	8-1-2016
333-015-0305	6-24-2016	Adopt	8-1-2016
333-015-0310	6-24-2016	Adopt	8-1-2016
333-015-0320	6-24-2016	Adopt	8-1-2016
333-015-0325	6-24-2016	Adopt	8-1-2016
333-015-0340	6-24-2016	Adopt	8-1-2016
333-015-0345	6-24-2016	Adopt	8-1-2016
333-015-0350	6-24-2016	Adopt	8-1-2016
333-015-0355	6-24-2016	Adopt	8-1-2016
333-015-0360	6-24-2016	Adopt	8-1-2016
333-015-0365	6-24-2016	Adopt	8-1-2016
333-015-0370	6-24-2016	Adopt	8-1-2016
333-015-0375	6-24-2016	Adopt	8-1-2016
333-016-2000	1-1-2016	Adopt	2-1-2016
333-016-2010	1-1-2016	Adopt	2-1-2016
333-016-2020	1-1-2016	Adopt	2-1-2016
333-016-2030	1-1-2016	Adopt	2-1-2016
333-018-0015	2-18-2016	Amend(T)	4-1-2016
333-028-0300	1-29-2016	Adopt	3-1-2016
333-028-0310	1-29-2016	Adopt	3-1-2016
333-028-0320	1-29-2016	Adopt	3-1-2016
333-028-0330	1-29-2016	Adopt	3-1-2016
333-028-0340	1-29-2016	Adopt	3-1-2016
333-028-0350	1-29-2016	Adopt	3-1-2016
333-030-0015	5-9-2016	Amend	6-1-2016
333-030-0020	5-9-2016	Amend	6-1-2016
333-030-0023	5-9-2016	Adopt	6-1-2016
333-030-0100	5-9-2016	Amend	6-1-2016
333-030-0110	5-9-2016	Amend	6-1-2016
333-030-0120	5-9-2016	Amend	6-1-2016
333-050-0010	1-20-2016	Amend	3-1-2016
333-050-0010(T)	1-20-2016	Repeal	3-1-2016
333-050-0040	1-20-2016	Amend	3-1-2016
333-050-0040(T)	1-20-2016	Repeal	3-1-2016
333-050-0050	1-20-2016	Amend	3-1-2016
333-050-0050(T)	1-20-2016	Repeal	3-1-2016
333-050-0080	1-20-2016	Amend	3-1-2016
333-050-0080(T)	1-20-2016	Repeal	3-1-2016
333-050-0095	1-20-2016	Amend	3-1-2016
333-050-0095(T)	1-20-2016	Repeal	3-1-2016
333-050-0100	1-20-2016	Amend	3-1-2016
333-050-0100(T)	1-20-2016	Repeal	3-1-2016
333-050-0110	1-20-2016	Amend	3-1-2016
333-050-0110(T)	1-20-2016	Repeal	3-1-2016
333-052-0040	1-1-2016	Amend	1-1-2016
333-052-0043	1-1-2016	Amend	1-1-2016
333-052-0080	1-1-2016	Amend	1-1-2016
333-052-0120	1-1-2016	Amend	1-1-2016
333-053-0040	1-1-2016	Amend	1-1-2016
333-053-0050	1-1-2016	Amend	1-1-2016
333-053-0080	1-1-2016	Amend	1-1-2016
333-054-0010	1-1-2016	Amend	1-1-2016
333-054-0020	1-1-2016	Amend	1-1-2016
333-054-0050	1-1-2016	Amend	1-1-2016
333-054-0060	1-1-2016	Amend	1-1-2016
333-054-0070	1-1-2016	Amend	1-1-2016
333-055-0000	2-8-2016	Amend	3-1-2016
333-055-0006	2-8-2016	Amend	3-1-2016
333-055-0015	2-8-2016	Amend	3-1-2016
333-055-0021	2-8-2016	Amend	3-1-2016
333-055-0030	2-8-2016	Amend	3-1-2016
333-055-0035	2-8-2016	Amend	3-1-2016
333-061-0020	4-1-2016	Amend	3-1-2016
333-061-0030	4-1-2016	Amend	3-1-2016
333-061-0031	4-1-2016	Amend	3-1-2016
333-061-0032	4-1-2016	Amend	3-1-2016
333-061-0036	4-1-2016	Amend	3-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
333-061-0040	4-1-2016	Amend	3-1-2016
333-061-0042	4-1-2016	Amend	3-1-2016
333-061-0043	4-1-2016	Amend	3-1-2016
333-061-0045	4-1-2016	Amend	3-1-2016
333-061-0050	4-1-2016	Amend	3-1-2016
333-061-0060	1-1-2016	Amend	1-1-2016
333-061-0060	4-1-2016	Amend	3-1-2016
333-061-0063	4-1-2016	Amend	3-1-2016
333-061-0065	4-1-2016	Amend	3-1-2016
333-061-0070	4-1-2016	Amend	3-1-2016
333-061-0071	4-1-2016	Amend	3-1-2016
333-061-0072	1-1-2016	Amend	1-1-2016
333-061-0073	1-1-2016	Amend	1-1-2016
333-061-0075	4-1-2016	Amend	3-1-2016
333-061-0076	1-1-2016	Amend	1-1-2016
333-061-0076	4-1-2016	Amend	3-1-2016
333-061-0077	4-1-2016	Amend	3-1-2016
333-061-0078	4-1-2016	Adopt	3-1-2016
333-061-0090	4-1-2016	Amend	3-1-2016
333-061-0097	4-1-2016	Amend	3-1-2016
333-061-0235	4-1-2016	Amend	3-1-2016
333-061-0265	1-1-2016	Amend	1-1-2016
333-064-0005	1-1-2016	Amend(T)	2-1-2016
333-064-0005	6-7-2016	Amend	7-1-2016
333-064-0010	1-1-2016	Amend(T)	2-1-2016
333-064-0010	6-7-2016	Amend	7-1-2016
333-064-0025	1-1-2016	Amend(T)	2-1-2016
333-064-0025	6-7-2016	Amend	7-1-2016
333-064-0060	1-1-2016	Amend(T)	2-1-2016
333-064-0060	6-7-2016	Amend	7-1-2016
333-064-0065	6-7-2016	Amend	7-1-2016
333-064-0100	6-28-2016	Amend	8-1-2016
333-064-0100(T)	6-28-2016	Repeal	8-1-2016
333-064-0110	6-28-2016	Amend	8-1-2016
333-064-0110(T)	6-28-2016	Repeal	8-1-2016
333-076-0101	2-24-2016	Amend	4-1-2016
333-076-0135	2-24-2016	Amend	4-1-2016
333-076-0137	2-24-2016	Adopt	4-1-2016
333-103-0025	1-1-2016	Amend	2-1-2016
333-200-0000	1-1-2016	Amend	1-1-2016
333-200-0010	1-1-2016	Amend	1-1-2016
333-200-0020	1-1-2016	Amend	1-1-2016
333-200-0030	1-1-2016	Amend	1-1-2016
333-200-0035	1-1-2016	Amend	1-1-2016
333-200-0040	1-1-2016	Amend	1-1-2016
333-200-0050	1-1-2016	Amend	1-1-2016
333-200-0060	1-1-2016	Amend	1-1-2016
333-200-0070	1-1-2016	Amend	1-1-2016
333-200-0080	1-1-2016	Amend	1-1-2016
333-200-0090	1-1-2016	Amend	1-1-2016
333-200-0235	1-1-2016	Adopt	1-1-2016
333-200-0245	1-1-2016	Adopt	1-1-2016
333-200-0250	1-1-2016	Adopt	1-1-2016
333-200-0255	1-1-2016	Adopt	1-1-2016
333-200-0265	1-1-2016	Adopt	1-1-2016
333-200-0275	1-1-2016	Adopt	1-1-2016
333-200-0285	1-1-2016	Adopt	1-1-2016
333-200-0295	1-1-2016	Adopt	1-1-2016
333-200-0300	1-1-2016	Adopt	1-1-2016
333-205-0000	1-1-2016	Amend	1-1-2016
333-205-0010	1-1-2016	Amend	1-1-2016
333-205-0020	1-1-2016	Amend	1-1-2016
333-205-0040	1-1-2016	Amend	1-1-2016
333-205-0050	1-1-2016	Amend	1-1-2016
333-250-0040	4-28-2016	Amend	6-1-2016
333-250-0041	4-28-2016	Amend	6-1-2016
333-250-0085	4-28-2016	Adopt	6-1-2016
333-265-0056	4-7-2016	Adopt	5-1-2016
333-500-0045	2-24-2016	Amend	4-1-2016
333-501-0035	7-1-2016	Amend	8-1-2016
333-501-0040	7-1-2016	Amend	8-1-2016
333-501-0045	7-1-2016	Amend	8-1-2016
333-505-0005	2-24-2016	Amend	4-1-2016
333-505-0007	2-24-2016	Amend	4-1-2016
333-505-0030	2-24-2016	Amend	4-1-2016
333-505-0050	2-24-2016	Amend	4-1-2016
333-510-0002	7-1-2016	Amend	8-1-2016
333-510-0030	2-24-2016	Amend	4-1-2016
333-510-0045	7-1-2016	Amend	8-1-2016
333-510-0105	7-1-2016	Adopt	8-1-2016
333-510-0110	7-1-2016	Adopt	8-1-2016
333-510-0115	7-1-2016	Adopt	8-1-2016
333-510-0120	7-1-2016	Adopt	8-1-2016
333-510-0125	7-1-2016	Adopt	8-1-2016
333-510-0130	7-1-2016	Adopt	8-1-2016
333-510-0135	7-1-2016	Adopt	8-1-2016
333-510-0140	7-1-2016	Adopt	8-1-2016
333-515-0030	2-24-2016	Amend	4-1-2016
333-515-0050	2-24-2016	Repeal	4-1-2016
333-515-0060	2-24-2016	Repeal	4-1-2016
333-520-0020	2-24-2016	Amend	4-1-2016
333-520-0050	2-24-2016	Amend	4-1-2016
333-525-0000	2-24-2016	Amend	4-1-2016
333-535-0061	2-24-2016	Amend	4-1-2016
333-535-0080	2-24-2016	Amend	4-1-2016
333-535-0110	2-24-2016	Amend	4-1-2016
334-010-0015	7-1-2016	Amend	7-1-2016
334-010-0017	7-1-2016	Amend	7-1-2016
334-010-0018	7-1-2016	Amend	7-1-2016
334-010-0033	7-1-2016	Amend	7-1-2016
334-010-0050	7-1-2016	Amend	7-1-2016
340-012-0054	1-1-2016	Amend	1-1-2016
340-012-0135	1-1-2016	Amend	1-1-2016
340-012-0140	1-1-2016	Amend	1-1-2016
340-039-0001	12-10-2015	Adopt	1-1-2016
340-039-0003	12-10-2015	Adopt	1-1-2016
340-039-0005	12-10-2015	Adopt	1-1-2016
340-039-0015	12-10-2015	Adopt	1-1-2016
340-039-0017	12-10-2015	Adopt	1-1-2016
340-039-0020	12-10-2015	Adopt	1-1-2016
340-039-0025	12-10-2015	Adopt	1-1-2016
340-039-0030	12-10-2015	Adopt	1-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
340-039-0035	12-10-2015	Adopt	1-1-2016
340-039-0040	12-10-2015	Adopt	1-1-2016
340-039-0043	12-10-2015	Adopt	1-1-2016
340-045-0075	1-1-2016	Amend	1-1-2016
340-071-0140	1-1-2016	Amend	1-1-2016
340-071-0140	1-27-2016	Amend	3-1-2016
340-083-0010	2-4-2016	Amend	3-1-2016
340-083-0020	2-4-2016	Amend	3-1-2016
340-083-0030	2-4-2016	Amend	3-1-2016
340-083-0040	2-4-2016	Amend	3-1-2016
340-083-0050	2-4-2016	Amend	3-1-2016
340-083-0070	2-4-2016	Amend	3-1-2016
340-083-0080	2-4-2016	Amend	3-1-2016
340-083-0090	2-4-2016	Amend	3-1-2016
340-083-0100	2-4-2016	Amend	3-1-2016
340-083-0500	2-4-2016	Adopt	3-1-2016
340-083-0510	2-4-2016	Adopt	3-1-2016
340-083-0520	2-4-2016	Adopt	3-1-2016
340-083-0530	2-4-2016	Adopt	3-1-2016
340-097-0001	2-4-2016	Amend	3-1-2016
340-097-0110	2-4-2016	Amend	3-1-2016
340-097-0120	2-4-2016	Amend	3-1-2016
340-200-0040	12-10-2015	Amend	1-1-2016
340-215-0010	12-10-2015	Amend	1-1-2016
340-215-0020	12-10-2015	Amend	1-1-2016
340-215-0030	12-10-2015	Amend	1-1-2016
340-215-0040	12-10-2015	Amend	1-1-2016
340-215-0060	12-10-2015	Amend	1-1-2016
340-220-0030	6-9-2016	Amend	7-1-2016
340-220-0040	6-9-2016	Amend	7-1-2016
340-220-0050	6-9-2016	Amend	7-1-2016
340-244-0010	4-21-2016	Amend(T)	6-1-2016
340-244-9000	4-21-2016	Adopt(T)	6-1-2016
340-244-9010	4-21-2016	Adopt(T)	6-1-2016
340-244-9020	4-21-2016	Adopt(T)	6-1-2016
340-244-9030	4-21-2016	Adopt(T)	6-1-2016
340-244-9040	4-21-2016	Adopt(T)	6-1-2016
340-244-9050	4-21-2016	Adopt(T)	6-1-2016
340-244-9060	4-21-2016	Adopt(T)	6-1-2016
340-244-9070	4-21-2016	Adopt(T)	6-1-2016
340-244-9070	5-6-2016	Amend(T)	6-1-2016
340-244-9080	4-21-2016	Adopt(T)	6-1-2016
340-244-9090	4-21-2016	Adopt(T)	6-1-2016
340-248-0250	1-1-2016	Amend(T)	1-1-2016
340-248-0250	4-21-2016	Amend	6-1-2016
340-248-0270	1-1-2016	Amend(T)	1-1-2016
340-248-0270	4-21-2016	Amend	6-1-2016
340-253-0000	1-1-2016	Amend	1-1-2016
340-253-0040	1-1-2016	Amend	1-1-2016
340-253-0060	1-1-2016	Amend	1-1-2016
340-253-0100	1-1-2016	Amend	1-1-2016
340-253-0200	1-1-2016	Amend	1-1-2016
340-253-0250	1-1-2016	Amend	1-1-2016
340-253-0310	1-1-2016	Amend	1-1-2016
340-253-0320	1-1-2016	Amend	1-1-2016
340-253-0330	1-1-2016	Amend	1-1-2016
340-253-0340	1-1-2016	Amend	1-1-2016
340-253-0400	1-1-2016	Amend	1-1-2016
340-253-0450	1-1-2016	Amend	1-1-2016
340-253-0500	1-1-2016	Amend	1-1-2016
340-253-0600	1-1-2016	Amend	1-1-2016
340-253-0620	1-1-2016	Amend	1-1-2016
340-253-0630	1-1-2016	Amend	1-1-2016
340-253-0650	1-1-2016	Amend	1-1-2016
340-253-1000	1-1-2016	Amend	1-1-2016
340-253-1010	1-1-2016	Amend	1-1-2016
340-253-1020	1-1-2016	Amend	1-1-2016
340-253-1030	1-1-2016	Amend	1-1-2016
340-253-1050	1-1-2016	Amend	1-1-2016
340-253-2000	1-1-2016	Amend	1-1-2016
340-253-2100	1-1-2016	Amend	1-1-2016
340-253-2200	1-1-2016	Amend	1-1-2016
340-253-8010	1-1-2016	Amend	1-1-2016
340-253-8010	4-22-2016	Amend(T)	6-1-2016
340-253-8020	1-1-2016	Amend	1-1-2016
340-253-8020	4-22-2016	Amend(T)	6-1-2016
340-253-8030	1-1-2016	Amend	1-1-2016
340-253-8030	4-22-2016	Amend(T)	6-1-2016
340-253-8040	1-1-2016	Amend	1-1-2016
340-253-8040	4-22-2016	Amend(T)	6-1-2016
340-253-8050	1-1-2016	Amend	1-1-2016
340-253-8060	1-1-2016	Amend	1-1-2016
340-253-8070	1-1-2016	Amend	1-1-2016
340-253-8080	1-1-2016	Amend	1-1-2016
407-007-0000	1-14-2016	Amend(T)	2-1-2016
407-007-0000	6-15-2016	Amend	7-1-2016
407-007-0000(T)	6-15-2016	Repeal	7-1-2016
407-007-0010	1-14-2016	Amend(T)	2-1-2016
407-007-0010	6-15-2016	Amend	7-1-2016
407-007-0010(T)	6-15-2016	Repeal	7-1-2016
407-007-0020	1-14-2016	Amend(T)	2-1-2016
407-007-0020	6-15-2016	Amend	7-1-2016
407-007-0020(T)	6-15-2016	Repeal	7-1-2016
407-007-0030	1-14-2016	Amend(T)	2-1-2016
407-007-0030	6-15-2016	Amend	7-1-2016
407-007-0030(T)	6-15-2016	Repeal	7-1-2016
407-007-0040	6-15-2016	Repeal	7-1-2016
407-007-0050	1-14-2016	Amend(T)	2-1-2016
407-007-0050	6-15-2016	Amend	7-1-2016
407-007-0050(T)	6-15-2016	Repeal	7-1-2016
407-007-0060	1-14-2016	Amend(T)	2-1-2016
407-007-0060	6-15-2016	Amend	7-1-2016
407-007-0060(T)	6-15-2016	Repeal	7-1-2016
407-007-0065	1-14-2016	Amend(T)	2-1-2016
407-007-0065	6-15-2016	Amend	7-1-2016
407-007-0065(T)	6-15-2016	Repeal	7-1-2016
407-007-0070	1-14-2016	Amend(T)	2-1-2016
407-007-0070	6-15-2016	Amend	7-1-2016
407-007-0070(T)	6-15-2016	Repeal	7-1-2016
407-007-0075	1-14-2016	Suspend	2-1-2016
407-007-0075	6-15-2016	Repeal	7-1-2016
407-007-0080	1-14-2016	Amend(T)	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
407-007-0080	6-15-2016	Amend	7-1-2016
407-007-0080(T)	6-15-2016	Repeal	7-1-2016
407-007-0090	1-14-2016	Amend(T)	2-1-2016
407-007-0090	6-15-2016	Amend	7-1-2016
407-007-0090(T)	6-15-2016	Repeal	7-1-2016
407-007-0200	1-14-2016	Amend(T)	2-1-2016
407-007-0200	6-15-2016	Amend	7-1-2016
407-007-0200(T)	6-15-2016	Repeal	7-1-2016
407-007-0210	1-14-2016	Amend(T)	2-1-2016
407-007-0210	6-15-2016	Amend	7-1-2016
407-007-0210	7-1-2016	Amend(T)	8-1-2016
407-007-0210(T)	6-15-2016	Repeal	7-1-2016
407-007-0220	1-14-2016	Amend(T)	2-1-2016
407-007-0220	6-15-2016	Amend	7-1-2016
407-007-0220(T)	6-15-2016	Repeal	7-1-2016
407-007-0230	1-14-2016	Amend(T)	2-1-2016
407-007-0230	6-15-2016	Amend	7-1-2016
407-007-0230(T)	6-15-2016	Repeal	7-1-2016
407-007-0240	1-14-2016	Amend(T)	2-1-2016
407-007-0240	6-15-2016	Amend	7-1-2016
407-007-0240(T)	6-15-2016	Repeal	7-1-2016
407-007-0250	1-14-2016	Amend(T)	2-1-2016
407-007-0250	6-15-2016	Amend	7-1-2016
407-007-0250	7-1-2016	Amend(T)	8-1-2016
407-007-0250(T)	6-15-2016	Repeal	7-1-2016
407-007-0275	1-14-2016	Amend(T)	2-1-2016
407-007-0275	6-15-2016	Amend	7-1-2016
407-007-0275(T)	6-15-2016	Repeal	7-1-2016
407-007-0277	1-14-2016	Amend(T)	2-1-2016
407-007-0277	6-15-2016	Amend	7-1-2016
407-007-0277(T)	6-15-2016	Repeal	7-1-2016
407-007-0279	6-15-2016	Adopt	7-1-2016
407-007-0279	7-1-2016	Amend(T)	8-1-2016
407-007-0280	1-14-2016	Suspend	2-1-2016
407-007-0280	6-15-2016	Repeal	7-1-2016
407-007-0290	1-14-2016	Amend(T)	2-1-2016
407-007-0290	6-15-2016	Amend	7-1-2016
407-007-0290	7-1-2016	Amend(T)	8-1-2016
407-007-0290(T)	6-15-2016	Repeal	7-1-2016
407-007-0300	1-14-2016	Amend(T)	2-1-2016
407-007-0300	6-15-2016	Amend	7-1-2016
407-007-0300(T)	6-15-2016	Repeal	7-1-2016
407-007-0315	1-14-2016	Amend(T)	2-1-2016
407-007-0315	6-15-2016	Amend	7-1-2016
407-007-0315(T)	6-15-2016	Repeal	7-1-2016
407-007-0320	1-14-2016	Amend(T)	2-1-2016
407-007-0320	6-15-2016	Amend	7-1-2016
407-007-0320	7-1-2016	Amend(T)	8-1-2016
407-007-0320(T)	6-15-2016	Repeal	7-1-2016
407-007-0325	1-14-2016	Suspend	2-1-2016
407-007-0325	6-15-2016	Repeal	7-1-2016
407-007-0330	1-14-2016	Amend(T)	2-1-2016
407-007-0330	6-15-2016	Amend	7-1-2016
407-007-0330(T)	6-15-2016	Repeal	7-1-2016
407-007-0350	1-14-2016	Amend(T)	2-1-2016
407-007-0350	6-15-2016	Amend	7-1-2016
407-007-0350(T)	6-15-2016	Repeal	7-1-2016
407-007-0370	1-14-2016	Amend(T)	2-1-2016
407-007-0370	6-15-2016	Amend	7-1-2016
407-007-0370(T)	6-15-2016	Repeal	7-1-2016
407-007-0400	1-14-2016	Suspend	2-1-2016
407-045-0260	2-3-2016	Amend	3-1-2016
407-045-0350	2-3-2016	Amend	3-1-2016
407-045-0800	7-1-2016	Amend(T)	8-1-2016
407-045-0810	7-1-2016	Suspend	8-1-2016
407-045-0820	7-1-2016	Amend(T)	8-1-2016
407-045-0825	7-1-2016	Adopt(T)	8-1-2016
407-045-0830	7-1-2016	Suspend	8-1-2016
407-045-0850	7-1-2016	Suspend	8-1-2016
407-045-0860	7-1-2016	Suspend	8-1-2016
407-045-0870	7-1-2016	Suspend	8-1-2016
407-045-0880	7-1-2016	Suspend	8-1-2016
407-045-0885	7-1-2016	Adopt(T)	8-1-2016
407-045-0890	7-1-2016	Amend(T)	8-1-2016
407-045-0895	7-1-2016	Adopt(T)	8-1-2016
407-045-0900	7-1-2016	Suspend	8-1-2016
407-045-0910	7-1-2016	Amend(T)	8-1-2016
407-045-0920	7-1-2016	Suspend	8-1-2016
407-045-0930	7-1-2016	Suspend	8-1-2016
407-045-0940	7-1-2016	Amend(T)	8-1-2016
407-045-0950	7-1-2016	Amend(T)	8-1-2016
407-045-0955	7-1-2016	Adopt(T)	8-1-2016
407-045-0960	7-1-2016	Suspend	8-1-2016
407-045-0970	7-1-2016	Suspend	8-1-2016
407-045-0980	7-1-2016	Amend(T)	8-1-2016
409-015-0005	3-28-2016	Amend	5-1-2016
409-015-0010	3-28-2016	Amend	5-1-2016
409-015-0015	3-28-2016	Amend	5-1-2016
409-015-0030	3-28-2016	Amend	5-1-2016
409-015-0035	3-28-2016	Amend	5-1-2016
409-015-0040	3-28-2016	Repeal	5-1-2016
409-025-0100	1-5-2016	Amend	2-1-2016
409-025-0100	1-1-2017	Amend	8-1-2016
409-025-0110	1-5-2016	Amend	2-1-2016
409-025-0110	1-1-2017	Amend	8-1-2016
409-025-0120	1-5-2016	Amend	2-1-2016
409-025-0120	1-1-2017	Amend	8-1-2016
409-025-0130	1-5-2016	Amend	2-1-2016
409-025-0130	1-1-2017	Amend	8-1-2016
409-025-0140	1-5-2016	Amend	2-1-2016
409-025-0150	1-5-2016	Amend	2-1-2016
409-025-0150	1-1-2017	Amend	8-1-2016
409-025-0160	1-5-2016	Amend	2-1-2016
409-025-0170	1-5-2016	Amend	2-1-2016
409-026-0100	2-8-2016	Amend(T)	3-1-2016
409-026-0100	3-25-2016	Amend	5-1-2016
409-026-0100(T)	3-25-2016	Repeal	5-1-2016
409-026-0110	2-8-2016	Amend(T)	3-1-2016
409-026-0110	3-25-2016	Amend	5-1-2016
409-026-0110(T)	3-25-2016	Repeal	5-1-2016
409-026-0120	2-8-2016	Amend(T)	3-1-2016
409-026-0120	3-25-2016	Amend	5-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
409-026-0120(T)	3-25-2016	Repeal	5-1-2016
409-026-0130	2-8-2016	Amend(T)	3-1-2016
409-026-0130	3-25-2016	Amend	5-1-2016
409-026-0130(T)	3-25-2016	Repeal	5-1-2016
409-026-0140	2-8-2016	Amend(T)	3-1-2016
409-026-0140	3-25-2016	Amend	5-1-2016
409-026-0140(T)	3-25-2016	Repeal	5-1-2016
409-027-0005	7-8-2016	Adopt	8-1-2016
409-027-0015	7-8-2016	Adopt	8-1-2016
409-027-0025	7-8-2016	Adopt	8-1-2016
409-035-0020	11-24-2015	Amend	1-1-2016
409-035-0020	4-22-2016	Amend	6-1-2016
409-035-0020(T)	11-24-2015	Repeal	1-1-2016
409-055-0000	5-13-2016	Amend	6-1-2016
409-055-0010	1-1-2016	Amend(T)	2-1-2016
409-055-0010	5-13-2016	Amend	6-1-2016
409-055-0010(T)	5-13-2016	Repeal	6-1-2016
409-055-0020	5-13-2016	Amend	6-1-2016
409-055-0030	1-1-2016	Amend(T)	2-1-2016
409-055-0030	5-13-2016	Amend	6-1-2016
409-055-0030(T)	5-13-2016	Repeal	6-1-2016
409-055-0040	1-1-2016	Amend(T)	2-1-2016
409-055-0040	5-13-2016	Amend	6-1-2016
409-055-0040(T)	5-13-2016	Repeal	6-1-2016
409-055-0045	5-13-2016	Amend	6-1-2016
409-055-0050	5-13-2016	Amend	6-1-2016
409-055-0060	1-1-2016	Amend(T)	2-1-2016
409-055-0060	5-13-2016	Amend	6-1-2016
409-055-0060(T)	5-13-2016	Repeal	6-1-2016
409-055-0070	1-1-2016	Amend(T)	2-1-2016
409-055-0070	5-13-2016	Amend	6-1-2016
409-055-0070(T)	5-13-2016	Repeal	6-1-2016
409-055-0080	5-13-2016	Amend	6-1-2016
409-055-0090	5-13-2016	Amend	6-1-2016
409-060-0110	4-19-2016	Amend	6-1-2016
409-060-0120	4-19-2016	Amend	6-1-2016
409-060-0150	4-19-2016	Amend	6-1-2016
409-062-0000	4-22-2016	Adopt(T)	6-1-2016
409-062-0010	4-22-2016	Adopt(T)	6-1-2016
409-062-0020	4-22-2016	Adopt(T)	6-1-2016
409-062-0030	4-22-2016	Adopt(T)	6-1-2016
409-062-0040	4-22-2016	Adopt(T)	6-1-2016
409-062-0050	4-22-2016	Adopt(T)	6-1-2016
409-062-0060	4-22-2016	Adopt(T)	6-1-2016
409-110-0025	5-9-2016	Adopt(T)	6-1-2016
409-110-0030	5-9-2016	Adopt(T)	6-1-2016
409-110-0035	5-9-2016	Adopt(T)	6-1-2016
409-110-0040	5-9-2016	Adopt(T)	6-1-2016
409-110-0045	5-9-2016	Adopt(T)	6-1-2016
410-050-0861	4-1-2016	Amend(T)	5-1-2016
410-120-0000	7-1-2016	Amend	8-1-2016
410-120-0000	7-1-2016	Amend	8-1-2016
410-120-0006	1-1-2016	Amend	1-1-2016
410-120-0006	7-1-2016	Amend	8-1-2016
410-120-1340	1-1-2016	Amend(T)	2-1-2016
410-120-1340	3-1-2016	Amend	4-1-2016
410-120-1340(T)	3-1-2016	Repeal	4-1-2016
410-121-0000	1-1-2016	Amend	2-1-2016
410-121-0030	12-27-2015	Amend	2-1-2016
410-121-0030	1-1-2016	Amend(T)	2-1-2016
410-121-0030	5-1-2016	Amend(T)	6-1-2016
410-121-0030	6-28-2016	Amend	8-1-2016
410-121-0030	7-1-2016	Amend(T)	8-1-2016
410-121-0030(T)	12-27-2015	Repeal	2-1-2016
410-121-0030(T)	6-28-2016	Repeal	8-1-2016
410-121-0040	12-27-2015	Amend	2-1-2016
410-121-0040	1-1-2016	Amend(T)	2-1-2016
410-121-0040	2-12-2016	Amend(T)	3-1-2016
410-121-0040	5-1-2016	Amend(T)	6-1-2016
410-121-0040	6-28-2016	Amend	8-1-2016
410-121-0040	7-1-2016	Amend(T)	8-1-2016
410-121-0040(T)	12-27-2015	Repeal	2-1-2016
410-121-0040(T)	6-28-2016	Repeal	8-1-2016
410-121-0135	1-1-2016	Amend	2-1-2016
410-121-0146	1-1-2016	Amend	2-1-2016
410-121-4000	1-1-2016	Am. & Ren.	2-1-2016
410-121-4005	1-1-2016	Am. & Ren.	2-1-2016
410-121-4010	1-1-2016	Am. & Ren.	2-1-2016
410-121-4015	1-1-2016	Renumber	2-1-2016
410-121-4020	1-1-2016	Renumber	2-1-2016
410-122-0186	2-3-2016	Amend	3-1-2016
410-122-0204	3-1-2016	Amend	4-1-2016
410-122-0211	4-1-2016	Amend	5-1-2016
410-122-0240	3-1-2016	Amend	4-1-2016
410-122-0300	3-1-2016	Amend	4-1-2016
410-122-0360	3-1-2016	Amend	4-1-2016
410-122-0365	3-1-2016	Amend	4-1-2016
410-122-0380	3-1-2016	Amend	4-1-2016
410-122-0475	3-1-2016	Amend	4-1-2016
410-122-0480	3-1-2016	Amend	4-1-2016
410-122-0510	3-1-2016	Amend	4-1-2016
410-122-0525	3-1-2016	Amend	4-1-2016
410-122-0640	3-1-2016	Amend	4-1-2016
410-122-0678	3-1-2016	Amend	4-1-2016
410-123-1060	7-1-2016	Amend	8-1-2016
410-123-1220	5-10-2016	Amend(T)	6-1-2016
410-123-1240	12-1-2015	Amend	1-1-2016
410-123-1240(T)	12-1-2015	Repeal	1-1-2016
410-123-1260	1-1-2016	Amend(T)	2-1-2016
410-123-1260	2-9-2016	Amend(T)	3-1-2016
410-123-1260	7-1-2016	Amend	8-1-2016
410-123-1260	7-13-2016	Amend	8-1-2016
410-123-1260(T)	7-1-2016	Repeal	8-1-2016
410-123-1510	1-1-2016	Adopt(T)	2-1-2016
410-123-1510	6-28-2016	Adopt	8-1-2016
410-123-1510(T)	6-28-2016	Repeal	8-1-2016
410-125-0080	7-1-2016	Amend	8-1-2016
410-125-0141	7-1-2016	Amend	8-1-2016
410-125-0400	7-1-2016	Amend	8-1-2016
410-130-0200	12-1-2015	Amend(T)	1-1-2016
410-130-0200	1-1-2016	Amend	2-1-2016
410-130-0200(T)	1-1-2016	Repeal	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
410-130-0220	3-4-2016	Amend(T)	4-1-2016
410-130-0220	5-1-2016	Amend	6-1-2016
410-130-0220(T)	5-1-2016	Repeal	6-1-2016
410-133-0000	7-1-2016	Amend	8-1-2016
410-133-0040	7-1-2016	Amend	8-1-2016
410-133-0060	7-1-2016	Amend	8-1-2016
410-133-0080	7-1-2016	Amend	8-1-2016
410-133-0100	7-1-2016	Amend	8-1-2016
410-133-0120	7-1-2016	Amend	8-1-2016
410-133-0140	7-1-2016	Amend	8-1-2016
410-133-0200	7-1-2016	Amend	8-1-2016
410-133-0300	7-1-2016	Amend	8-1-2016
410-133-0320	7-1-2016	Amend	8-1-2016
410-136-3040	1-1-2016	Amend	2-1-2016
410-140-0020	3-1-2016	Amend	4-1-2016
410-140-0040	3-1-2016	Amend	4-1-2016
410-140-0050	3-1-2016	Amend	4-1-2016
410-140-0080	3-1-2016	Amend	4-1-2016
410-140-0120	3-1-2016	Amend	4-1-2016
410-140-0140	3-1-2016	Amend	4-1-2016
410-140-0160	3-1-2016	Amend	4-1-2016
410-140-0200	3-1-2016	Amend	4-1-2016
410-140-0260	3-1-2016	Amend	4-1-2016
410-140-0280	3-1-2016	Amend	4-1-2016
410-140-0300	3-1-2016	Amend	4-1-2016
410-141-0000	12-10-2015	Amend	1-1-2016
410-141-0000	7-1-2016	Amend	8-1-2016
410-141-0080	12-10-2015	Amend	1-1-2016
410-141-0085	12-10-2015	Repeal	1-1-2016
410-141-0160	12-10-2015	Amend	1-1-2016
410-141-0220	12-10-2015	Amend	1-1-2016
410-141-0320	12-10-2015	Amend	1-1-2016
410-141-0340	12-10-2015	Amend	1-1-2016
410-141-0410	12-10-2015	Repeal	1-1-2016
410-141-0420	12-10-2015	Amend	1-1-2016
410-141-0420	7-1-2016	Repeal	8-1-2016
410-141-0520	1-1-2016	Amend(T)	2-1-2016
410-141-0520	3-1-2016	Amend	4-1-2016
410-141-0520	7-1-2016	Amend(T)	8-1-2016
410-141-0520(T)	3-1-2016	Repeal	4-1-2016
410-141-0660	12-10-2015	Repeal	1-1-2016
410-141-0680	12-10-2015	Repeal	1-1-2016
410-141-0700	12-10-2015	Repeal	1-1-2016
410-141-0720	12-10-2015	Repeal	1-1-2016
410-141-0740	12-10-2015	Repeal	1-1-2016
410-141-0760	12-10-2015	Repeal	1-1-2016
410-141-0780	12-10-2015	Repeal	1-1-2016
410-141-0800	12-10-2015	Repeal	1-1-2016
410-141-0820	12-10-2015	Repeal	1-1-2016
410-141-0840	12-10-2015	Repeal	1-1-2016
410-141-0860	12-10-2015	Amend	1-1-2016
410-141-3015	7-6-2016	Amend(T)	8-1-2016
410-141-3040	1-7-2016	Adopt	2-1-2016
410-141-3040(T)	1-7-2016	Repeal	2-1-2016
410-141-3060	1-1-2016	Amend(T)	2-1-2016
410-141-3060	6-28-2016	Amend	8-1-2016
410-141-3060(T)	6-28-2016	Repeal	8-1-2016
410-141-3070	7-1-2016	Amend	8-1-2016
410-141-3080	12-10-2015	Amend	1-1-2016
410-141-3080	1-1-2016	Amend(T)	2-1-2016
410-141-3080	6-28-2016	Amend	8-1-2016
410-141-3080(T)	6-28-2016	Repeal	8-1-2016
410-141-3110	7-1-2016	Adopt	8-1-2016
410-141-3145	7-6-2016	Amend(T)	8-1-2016
410-141-3150	1-1-2016	Adopt	2-1-2016
410-141-3150(T)	1-1-2016	Repeal	2-1-2016
410-141-3260	7-6-2016	Amend(T)	8-1-2016
410-141-3262	7-1-2016	Amend	8-1-2016
410-141-3267	12-27-2015	Adopt	2-1-2016
410-141-3267(T)	12-27-2015	Repeal	2-1-2016
410-141-3300	7-6-2016	Amend(T)	8-1-2016
410-141-3345	1-1-2016	Amend(T)	2-1-2016
410-141-3345	3-1-2016	Amend	3-1-2016
410-141-3345(T)	3-1-2016	Repeal	3-1-2016
410-141-3420	7-1-2016	Amend	8-1-2016
410-141-3440	1-1-2016	Amend	2-1-2016
410-165-0000	5-13-2016	Amend(T)	6-1-2016
410-165-0020	5-13-2016	Amend(T)	6-1-2016
410-165-0040	5-13-2016	Amend(T)	6-1-2016
410-165-0060	5-13-2016	Amend(T)	6-1-2016
410-165-0080	5-13-2016	Amend(T)	6-1-2016
410-165-0100	5-13-2016	Amend(T)	6-1-2016
410-165-0120	5-13-2016	Amend(T)	6-1-2016
410-165-0140	5-13-2016	Amend(T)	6-1-2016
410-170-0110	2-7-2016	Amend(T)	3-1-2016
410-170-0110	2-23-2016	Amend	4-1-2016
410-170-0110	6-3-2016	Amend(T)	7-1-2016
410-170-0110(T)	2-23-2016	Repeal	4-1-2016
410-172-0660	4-15-2016	Amend(T)	5-1-2016
410-200-0015	12-22-2015	Amend(T)	2-1-2016
410-200-0015	6-3-2016	Amend	7-1-2016
410-200-0015(T)	6-3-2016	Repeal	7-1-2016
410-200-0100	12-22-2015	Amend(T)	2-1-2016
410-200-0100	6-3-2016	Amend	7-1-2016
410-200-0100(T)	6-3-2016	Repeal	7-1-2016
410-200-0105	12-22-2015	Amend(T)	2-1-2016
410-200-0105	6-3-2016	Amend	7-1-2016
410-200-0105(T)	6-3-2016	Repeal	7-1-2016
410-200-0110	12-22-2015	Amend(T)	2-1-2016
410-200-0110	6-3-2016	Amend	7-1-2016
410-200-0110(T)	6-3-2016	Repeal	7-1-2016
410-200-0111	12-22-2015	Amend(T)	2-1-2016
410-200-0111	6-3-2016	Amend	7-1-2016
410-200-0111(T)	6-3-2016	Repeal	7-1-2016
410-200-0115	12-22-2015	Amend(T)	2-1-2016
410-200-0115	6-3-2016	Amend	7-1-2016
410-200-0115(T)	6-3-2016	Repeal	7-1-2016
410-200-0120	12-22-2015	Amend(T)	2-1-2016
410-200-0120	6-3-2016	Amend	7-1-2016
410-200-0120(T)	6-3-2016	Repeal	7-1-2016
410-200-0125	12-22-2015	Amend(T)	2-1-2016
410-200-0125	6-3-2016	Amend	7-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
410-200-0125(T)	6-3-2016	Repeal	7-1-2016
410-200-0130	12-22-2015	Amend(T)	2-1-2016
410-200-0130	6-3-2016	Amend	7-1-2016
410-200-0130(T)	6-3-2016	Repeal	7-1-2016
410-200-0135	12-22-2015	Amend(T)	2-1-2016
410-200-0135	6-3-2016	Amend	7-1-2016
410-200-0135(T)	6-3-2016	Repeal	7-1-2016
410-200-0140	12-22-2015	Amend(T)	2-1-2016
410-200-0140	6-3-2016	Amend	7-1-2016
410-200-0140(T)	6-3-2016	Repeal	7-1-2016
410-200-0200	12-22-2015	Amend(T)	2-1-2016
410-200-0200	6-3-2016	Amend	7-1-2016
410-200-0200(T)	6-3-2016	Repeal	7-1-2016
410-200-0215	12-22-2015	Amend(T)	2-1-2016
410-200-0215	6-3-2016	Amend	7-1-2016
410-200-0215(T)	6-3-2016	Repeal	7-1-2016
410-200-0230	12-22-2015	Amend(T)	2-1-2016
410-200-0230	6-3-2016	Amend	7-1-2016
410-200-0230(T)	6-3-2016	Repeal	7-1-2016
410-200-0235	12-22-2015	Amend(T)	2-1-2016
410-200-0235	6-3-2016	Amend	7-1-2016
410-200-0235(T)	6-3-2016	Repeal	7-1-2016
410-200-0240	12-22-2015	Amend(T)	2-1-2016
410-200-0240	6-3-2016	Amend	7-1-2016
410-200-0240(T)	6-3-2016	Repeal	7-1-2016
410-200-0310	12-22-2015	Amend(T)	2-1-2016
410-200-0310	6-3-2016	Amend	7-1-2016
410-200-0310(T)	6-3-2016	Repeal	7-1-2016
410-200-0315	3-1-2016	Amend(T)	4-1-2016
410-200-0315	5-18-2016	Amend	7-1-2016
410-200-0315(T)	5-18-2016	Repeal	7-1-2016
410-200-0407	12-18-2015	Adopt(T)	2-1-2016
410-200-0407	6-2-2016	Adopt	7-1-2016
410-200-0407(T)	6-2-2016	Repeal	7-1-2016
410-200-0415	12-22-2015	Amend(T)	2-1-2016
410-200-0415	6-3-2016	Amend	7-1-2016
410-200-0415(T)	6-3-2016	Repeal	7-1-2016
410-200-0425	12-22-2015	Amend(T)	2-1-2016
410-200-0425	6-3-2016	Amend	7-1-2016
410-200-0425(T)	6-3-2016	Repeal	7-1-2016
410-200-0440	12-22-2015	Amend(T)	2-1-2016
410-200-0440	6-3-2016	Amend	7-1-2016
410-200-0440(T)	6-3-2016	Repeal	7-1-2016
410-200-0500	12-22-2015	Suspend	2-1-2016
410-200-0500	6-3-2016	Repeal	7-1-2016
410-200-0505	12-22-2015	Amend(T)	2-1-2016
410-200-0505	6-3-2016	Amend	7-1-2016
410-200-0505(T)	6-3-2016	Repeal	7-1-2016
410-200-0510	12-22-2015	Amend(T)	2-1-2016
410-200-0510	6-3-2016	Amend	7-1-2016
410-200-0510(T)	6-3-2016	Repeal	7-1-2016
411-004-0000	1-1-2016	Adopt	1-1-2016
411-004-0010	1-1-2016	Adopt	1-1-2016
411-004-0020	1-1-2016	Adopt	1-1-2016
411-004-0020	1-1-2016	Amend	2-1-2016
411-004-0030	1-1-2016	Adopt	1-1-2016
411-004-0040	1-1-2016	Adopt	1-1-2016
411-004-0040	7-1-2016	Amend(T)	8-1-2016
411-020-0002	1-1-2016	Amend(T)	2-1-2016
411-020-0002	5-6-2016	Amend	6-1-2016
411-020-0002(T)	5-6-2016	Repeal	6-1-2016
411-027-0005	3-18-2016	Amend	4-1-2016
411-027-0005(T)	3-18-2016	Repeal	4-1-2016
411-027-0170	3-18-2016	Adopt	4-1-2016
411-027-0170	7-1-2016	Amend(T)	8-1-2016
411-027-0170(T)	3-18-2016	Repeal	4-1-2016
411-030-0020	3-18-2016	Amend	4-1-2016
411-030-0020(T)	3-18-2016	Repeal	4-1-2016
411-030-0068	3-18-2016	Adopt	4-1-2016
411-030-0068	7-1-2016	Amend(T)	8-1-2016
411-030-0068(T)	3-18-2016	Repeal	4-1-2016
411-030-0070	3-18-2016	Amend	4-1-2016
411-030-0070	7-1-2016	Amend(T)	8-1-2016
411-030-0070(T)	3-18-2016	Repeal	4-1-2016
411-030-0080	3-18-2016	Amend	4-1-2016
411-030-0080(T)	3-18-2016	Repeal	4-1-2016
411-030-0100	3-18-2016	Amend	4-1-2016
411-030-0100(T)	3-18-2016	Repeal	4-1-2016
411-031-0020	3-2-2016	Amend(T)	4-1-2016
411-031-0020	3-23-2016	Amend(T)	5-1-2016
411-031-0020(T)	3-23-2016	Suspend	5-1-2016
411-031-0040	3-2-2016	Amend(T)	4-1-2016
411-031-0040	3-23-2016	Amend(T)	5-1-2016
411-031-0040(T)	3-23-2016	Suspend	5-1-2016
411-031-0050	3-2-2016	Amend(T)	4-1-2016
411-031-0050	3-23-2016	Amend(T)	5-1-2016
411-031-0050(T)	3-23-2016	Suspend	5-1-2016
411-032-0050	12-27-2015	Amend	1-1-2016
411-032-0050(T)	12-27-2015	Repeal	1-1-2016
411-050-0602	1-1-2016	Amend(T)	2-1-2016
411-050-0602	6-28-2016	Amend	8-1-2016
411-050-0602(T)	6-28-2016	Repeal	8-1-2016
411-050-0610	6-28-2016	Amend	8-1-2016
411-050-0615	1-1-2016	Amend(T)	2-1-2016
411-050-0615	6-28-2016	Amend	8-1-2016
411-050-0615(T)	6-28-2016	Repeal	8-1-2016
411-050-0625	6-28-2016	Amend	8-1-2016
411-050-0630	1-1-2016	Amend(T)	2-1-2016
411-050-0630	6-28-2016	Amend	8-1-2016
411-050-0630(T)	6-28-2016	Repeal	8-1-2016
411-050-0632	1-1-2016	Amend(T)	2-1-2016
411-050-0632	6-28-2016	Amend	8-1-2016
411-050-0632(T)	6-28-2016	Repeal	8-1-2016
411-050-0635	1-1-2016	Amend(T)	2-1-2016
411-050-0635	6-28-2016	Amend	8-1-2016
411-050-0635(T)	6-28-2016	Repeal	8-1-2016
411-050-0640	6-28-2016	Amend	8-1-2016
411-050-0642	1-1-2016	Amend(T)	2-1-2016
411-050-0642	6-28-2016	Amend	8-1-2016
411-050-0642(T)	6-28-2016	Repeal	8-1-2016
411-050-0645	1-1-2016	Amend(T)	2-1-2016
411-050-0645	6-28-2016	Amend	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
411-050-0645(T)	6-28-2016	Repeal	8-1-2016
411-050-0650	1-1-2016	Amend(T)	2-1-2016
411-050-0650	6-28-2016	Amend	8-1-2016
411-050-0650(T)	6-28-2016	Repeal	8-1-2016
411-050-0655	1-1-2016	Amend(T)	2-1-2016
411-050-0655	6-28-2016	Amend	8-1-2016
411-050-0655(T)	6-28-2016	Repeal	8-1-2016
411-050-0660	6-28-2016	Amend	8-1-2016
411-050-0662	1-1-2016	Amend(T)	2-1-2016
411-050-0662	6-28-2016	Amend	8-1-2016
411-050-0662(T)	6-28-2016	Repeal	8-1-2016
411-050-0665	1-1-2016	Amend(T)	2-1-2016
411-050-0665	6-28-2016	Amend	8-1-2016
411-050-0670	1-1-2016	Amend(T)	2-1-2016
411-050-0670	6-28-2016	Amend	8-1-2016
411-050-0670(T)	6-28-2016	Repeal	8-1-2016
411-050-0685	1-1-2016	Amend(T)	2-1-2016
411-050-0685	6-28-2016	Amend	8-1-2016
411-050-0685(T)	6-28-2016	Repeal	8-1-2016
411-054-0000	1-1-2016	Amend(T)	2-1-2016
411-054-0000	6-28-2016	Amend	8-1-2016
411-054-0000(T)	6-28-2016	Repeal	8-1-2016
411-054-0005	1-1-2016	Amend(T)	2-1-2016
411-054-0005	6-28-2016	Amend	8-1-2016
411-054-0005(T)	6-28-2016	Repeal	8-1-2016
411-054-0012	1-1-2016	Amend(T)	2-1-2016
411-054-0012	6-28-2016	Amend	8-1-2016
411-054-0012(T)	6-28-2016	Repeal	8-1-2016
411-054-0025	1-1-2016	Amend(T)	2-1-2016
411-054-0025	6-28-2016	Amend	8-1-2016
411-054-0025(T)	6-28-2016	Repeal	8-1-2016
411-054-0027	1-1-2016	Amend(T)	2-1-2016
411-054-0027	6-28-2016	Amend	8-1-2016
411-054-0027(T)	6-28-2016	Repeal	8-1-2016
411-054-0034	6-28-2016	Amend	8-1-2016
411-054-0036	1-1-2016	Amend(T)	2-1-2016
411-054-0036	6-28-2016	Amend	8-1-2016
411-054-0036(T)	6-28-2016	Repeal	8-1-2016
411-054-0038	1-1-2016	Adopt(T)	2-1-2016
411-054-0038	6-28-2016	Adopt	8-1-2016
411-054-0038(T)	6-28-2016	Repeal	8-1-2016
411-054-0065	6-28-2016	Amend	8-1-2016
411-054-0080	6-28-2016	Amend	8-1-2016
411-054-0120	6-28-2016	Amend	8-1-2016
411-070-0437	4-1-2016	Amend(T)	5-1-2016
411-070-0442	4-1-2016	Amend(T)	5-1-2016
411-070-0470	4-1-2016	Amend	4-1-2016
411-089-0030	4-1-2016	Amend	4-1-2016
411-300-0100	6-29-2016	Amend	8-1-2016
411-300-0110	1-1-2016	Amend(T)	2-1-2016
411-300-0110	6-29-2016	Amend	8-1-2016
411-300-0120	6-29-2016	Amend	8-1-2016
411-300-0130	1-1-2016	Amend(T)	2-1-2016
411-300-0130	6-29-2016	Repeal	8-1-2016
411-300-0150	1-1-2016	Amend(T)	2-1-2016
411-300-0150	6-29-2016	Amend	8-1-2016
411-300-0155	1-1-2016	Amend(T)	2-1-2016
411-300-0155	6-29-2016	Repeal	8-1-2016
411-300-0165	6-29-2016	Repeal	8-1-2016
411-300-0170	1-1-2016	Amend(T)	2-1-2016
411-300-0170	6-29-2016	Repeal	8-1-2016
411-300-0175	6-29-2016	Repeal	8-1-2016
411-300-0190	6-29-2016	Amend	8-1-2016
411-300-0200	6-29-2016	Repeal	8-1-2016
411-300-0205	6-29-2016	Amend	8-1-2016
411-308-0010	6-29-2016	Repeal	8-1-2016
411-308-0020	1-1-2016	Amend(T)	2-1-2016
411-308-0020	6-29-2016	Repeal	8-1-2016
411-308-0030	6-29-2016	Repeal	8-1-2016
411-308-0040	6-29-2016	Repeal	8-1-2016
411-308-0050	1-1-2016	Amend(T)	2-1-2016
411-308-0050	6-29-2016	Repeal	8-1-2016
411-308-0060	6-29-2016	Repeal	8-1-2016
411-308-0070	6-29-2016	Repeal	8-1-2016
411-308-0080	1-1-2016	Amend(T)	2-1-2016
411-308-0080	6-29-2016	Repeal	8-1-2016
411-308-0090	6-29-2016	Repeal	8-1-2016
411-308-0100	1-1-2016	Amend(T)	2-1-2016
411-308-0100	6-29-2016	Repeal	8-1-2016
411-308-0110	1-1-2016	Amend(T)	2-1-2016
411-308-0110	6-29-2016	Repeal	8-1-2016
411-308-0120	1-1-2016	Amend(T)	2-1-2016
411-308-0120	6-29-2016	Repeal	8-1-2016
411-308-0130	1-1-2016	Amend(T)	2-1-2016
411-308-0130	6-29-2016	Repeal	8-1-2016
411-308-0135	6-29-2016	Repeal	8-1-2016
411-308-0140	6-29-2016	Repeal	8-1-2016
411-308-0150	6-29-2016	Repeal	8-1-2016
411-317-0000	1-1-2016	Amend(T)	2-1-2016
411-317-0000	6-29-2016	Amend	8-1-2016
411-318-0000	1-1-2016	Amend(T)	2-1-2016
411-318-0000	6-29-2016	Amend	8-1-2016
411-318-0005	1-1-2016	Amend(T)	2-1-2016
411-318-0005	6-29-2016	Amend	8-1-2016
411-318-0010	1-1-2016	Amend(T)	2-1-2016
411-318-0010	6-29-2016	Amend	8-1-2016
411-320-0010	6-29-2016	Amend	8-1-2016
411-320-0020	1-1-2016	Amend(T)	2-1-2016
411-320-0020	6-29-2016	Amend	8-1-2016
411-320-0030	6-29-2016	Amend	8-1-2016
411-320-0040	1-1-2016	Amend(T)	2-1-2016
411-320-0040	6-29-2016	Amend	8-1-2016
411-320-0050	6-29-2016	Amend	8-1-2016
411-320-0060	1-1-2016	Amend(T)	2-1-2016
411-320-0060	6-29-2016	Repeal	8-1-2016
411-320-0070	6-29-2016	Amend	8-1-2016
411-320-0080	1-1-2016	Amend(T)	2-1-2016
411-320-0080	6-29-2016	Amend	8-1-2016
411-320-0090	1-1-2016	Amend(T)	2-1-2016
411-320-0090	6-29-2016	Repeal	8-1-2016
411-320-0100	6-29-2016	Repeal	8-1-2016
411-320-0110	1-1-2016	Amend(T)	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
411-320-0110	6-29-2016	Repeal	8-1-2016
411-320-0120	1-1-2016	Amend(T)	2-1-2016
411-320-0120	6-29-2016	Repeal	8-1-2016
411-320-0130	6-29-2016	Repeal	8-1-2016
411-320-0150	6-29-2016	Repeal	8-1-2016
411-320-0160	6-29-2016	Repeal	8-1-2016
411-320-0170	6-29-2016	Amend	8-1-2016
411-320-0180	6-29-2016	Amend	8-1-2016
411-323-0010	1-1-2016	Amend(T)	2-1-2016
411-323-0010	6-29-2016	Amend	8-1-2016
411-323-0020	1-1-2016	Amend(T)	2-1-2016
411-323-0020	6-29-2016	Amend	8-1-2016
411-323-0030	1-1-2016	Amend(T)	2-1-2016
411-323-0030	6-29-2016	Amend	8-1-2016
411-323-0035	1-1-2016	Amend(T)	2-1-2016
411-323-0035	6-29-2016	Amend	8-1-2016
411-323-0050	6-29-2016	Amend	8-1-2016
411-323-0060	1-1-2016	Amend(T)	2-1-2016
411-323-0060	6-29-2016	Amend	8-1-2016
411-323-0065	6-29-2016	Adopt	8-1-2016
411-323-0070	6-29-2016	Amend	8-1-2016
411-325-0010	1-1-2016	Amend(T)	2-1-2016
411-325-0010	6-29-2016	Amend	8-1-2016
411-325-0020	1-1-2016	Amend(T)	2-1-2016
411-325-0020	6-29-2016	Amend	8-1-2016
411-325-0025	6-29-2016	Amend	8-1-2016
411-325-0030	6-29-2016	Amend	8-1-2016
411-325-0040	1-1-2016	Amend(T)	2-1-2016
411-325-0040	6-29-2016	Amend	8-1-2016
411-325-0110	6-29-2016	Amend	8-1-2016
411-325-0130	1-1-2016	Amend(T)	2-1-2016
411-325-0130	6-29-2016	Amend	8-1-2016
411-325-0140	1-1-2016	Amend(T)	2-1-2016
411-325-0140	6-29-2016	Amend	8-1-2016
411-325-0150	1-1-2016	Amend(T)	2-1-2016
411-325-0150	6-29-2016	Amend	8-1-2016
411-325-0170	1-1-2016	Amend(T)	2-1-2016
411-325-0170	6-29-2016	Amend	8-1-2016
411-325-0220	1-1-2016	Amend(T)	2-1-2016
411-325-0220	6-29-2016	Amend	8-1-2016
411-325-0270	6-29-2016	Amend	8-1-2016
411-325-0280	6-29-2016	Amend	8-1-2016
411-325-0290	6-29-2016	Amend	8-1-2016
411-325-0300	1-1-2016	Amend(T)	2-1-2016
411-325-0300	6-29-2016	Amend	8-1-2016
411-325-0390	1-1-2016	Amend(T)	2-1-2016
411-325-0390	6-29-2016	Amend	8-1-2016
411-325-0410	6-29-2016	Amend	8-1-2016
411-325-0420	6-29-2016	Repeal	8-1-2016
411-325-0430	1-1-2016	Amend(T)	2-1-2016
411-325-0430	6-29-2016	Amend	8-1-2016
411-325-0460	6-29-2016	Amend	8-1-2016
411-328-0550	1-1-2016	Amend(T)	2-1-2016
411-328-0550	6-29-2016	Amend	8-1-2016
411-328-0560	1-1-2016	Amend(T)	2-1-2016
411-328-0560	6-29-2016	Amend	8-1-2016
411-328-0625	1-1-2016	Adopt(T)	2-1-2016
411-328-0625	6-29-2016	Adopt	8-1-2016
411-328-0630	1-1-2016	Amend(T)	2-1-2016
411-328-0640	6-29-2016	Amend	8-1-2016
411-328-0650	1-1-2016	Amend(T)	2-1-2016
411-328-0650	6-29-2016	Amend	8-1-2016
411-328-0700	6-29-2016	Amend	8-1-2016
411-328-0720	1-1-2016	Amend(T)	2-1-2016
411-328-0720	6-29-2016	Amend	8-1-2016
411-328-0750	1-1-2016	Amend(T)	2-1-2016
411-328-0750	6-29-2016	Amend	8-1-2016
411-328-0760	6-29-2016	Amend	8-1-2016
411-328-0770	6-29-2016	Amend	8-1-2016
411-328-0780	6-29-2016	Amend	8-1-2016
411-328-0790	1-1-2016	Amend(T)	2-1-2016
411-328-0790	6-29-2016	Amend	8-1-2016
411-330-0010	6-29-2016	Repeal	8-1-2016
411-330-0020	1-1-2016	Amend(T)	2-1-2016
411-330-0020	6-29-2016	Repeal	8-1-2016
411-330-0030	6-29-2016	Repeal	8-1-2016
411-330-0040	6-29-2016	Repeal	8-1-2016
411-330-0050	1-1-2016	Amend(T)	2-1-2016
411-330-0050	6-29-2016	Repeal	8-1-2016
411-330-0060	1-1-2016	Amend(T)	2-1-2016
411-330-0060	6-29-2016	Repeal	8-1-2016
411-330-0065	6-29-2016	Repeal	8-1-2016
411-330-0070	1-1-2016	Amend(T)	2-1-2016
411-330-0070	6-29-2016	Repeal	8-1-2016
411-330-0080	1-1-2016	Amend(T)	2-1-2016
411-330-0080	6-29-2016	Repeal	8-1-2016
411-330-0090	6-29-2016	Repeal	8-1-2016
411-330-0100	6-29-2016	Repeal	8-1-2016
411-330-0110	1-1-2016	Amend(T)	2-1-2016
411-330-0110	6-29-2016	Repeal	8-1-2016
411-330-0120	6-29-2016	Repeal	8-1-2016
411-330-0130	6-29-2016	Repeal	8-1-2016
411-330-0140	6-29-2016	Repeal	8-1-2016
411-330-0150	6-29-2016	Repeal	8-1-2016
411-330-0160	6-29-2016	Repeal	8-1-2016
411-330-0170	6-29-2016	Repeal	8-1-2016
411-340-0010	6-29-2016	Amend	8-1-2016
411-340-0020	1-1-2016	Amend(T)	2-1-2016
411-340-0020	6-29-2016	Amend	8-1-2016
411-340-0030	1-1-2016	Amend(T)	2-1-2016
411-340-0030	6-29-2016	Amend	8-1-2016
411-340-0040	6-29-2016	Amend	8-1-2016
411-340-0050	6-29-2016	Amend	8-1-2016
411-340-0060	6-29-2016	Amend	8-1-2016
411-340-0070	6-29-2016	Amend	8-1-2016
411-340-0080	6-29-2016	Amend	8-1-2016
411-340-0090	6-29-2016	Amend	8-1-2016
411-340-0100	6-29-2016	Amend	8-1-2016
411-340-0110	6-29-2016	Amend	8-1-2016
411-340-0120	1-1-2016	Amend(T)	2-1-2016
411-340-0120	6-29-2016	Amend	8-1-2016
411-340-0125	6-29-2016	Repeal	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
411-340-0130	1-1-2016	Amend(T)	2-1-2016
411-340-0130	6-29-2016	Repeal	8-1-2016
411-340-0135	6-29-2016	Repeal	8-1-2016
411-340-0140	1-1-2016	Amend(T)	2-1-2016
411-340-0140	6-29-2016	Repeal	8-1-2016
411-340-0150	1-1-2016	Amend(T)	2-1-2016
411-340-0150	6-29-2016	Amend	8-1-2016
411-340-0160	1-1-2016	Amend(T)	2-1-2016
411-340-0160	6-29-2016	Repeal	8-1-2016
411-340-0170	1-1-2016	Amend(T)	2-1-2016
411-340-0170	6-29-2016	Repeal	8-1-2016
411-340-0180	6-29-2016	Repeal	8-1-2016
411-345-0010	1-1-2016	Amend(T)	2-1-2016
411-345-0010	6-29-2016	Amend	8-1-2016
411-345-0020	1-1-2016	Amend(T)	2-1-2016
411-345-0020	6-29-2016	Amend	8-1-2016
411-345-0025	1-1-2016	Amend(T)	2-1-2016
411-345-0025	6-29-2016	Amend	8-1-2016
411-345-0027	6-29-2016	Amend	8-1-2016
411-345-0030	1-1-2016	Amend(T)	2-1-2016
411-345-0030	6-29-2016	Amend	8-1-2016
411-345-0085	1-1-2016	Amend(T)	2-1-2016
411-345-0085	6-29-2016	Amend	8-1-2016
411-345-0095	6-29-2016	Amend	8-1-2016
411-345-0110	1-1-2016	Amend(T)	2-1-2016
411-345-0110	6-29-2016	Amend	8-1-2016
411-345-0130	6-29-2016	Amend	8-1-2016
411-345-0140	6-29-2016	Amend	8-1-2016
411-345-0160	1-1-2016	Amend(T)	2-1-2016
411-345-0160	6-29-2016	Amend	8-1-2016
411-345-0170	6-29-2016	Amend	8-1-2016
411-345-0180	6-29-2016	Amend	8-1-2016
411-345-0190	6-29-2016	Amend	8-1-2016
411-345-0200	6-29-2016	Amend	8-1-2016
411-345-0230	6-29-2016	Amend	8-1-2016
411-345-0240	6-29-2016	Amend	8-1-2016
411-345-0250	6-29-2016	Amend	8-1-2016
411-345-0260	6-29-2016	Amend	8-1-2016
411-345-0270	6-29-2016	Amend	8-1-2016
411-346-0100	2-23-2016	Amend(T)	4-1-2016
411-346-0110	2-23-2016	Amend(T)	4-1-2016
411-346-0170	2-23-2016	Amend(T)	4-1-2016
411-346-0190	2-23-2016	Amend(T)	4-1-2016
411-346-0200	2-23-2016	Amend(T)	4-1-2016
411-350-0010	6-29-2016	Repeal	8-1-2016
411-350-0020	1-1-2016	Amend(T)	2-1-2016
411-350-0020	6-29-2016	Repeal	8-1-2016
411-350-0030	1-1-2016	Amend(T)	2-1-2016
411-350-0030	6-29-2016	Repeal	8-1-2016
411-350-0040	1-1-2016	Amend(T)	2-1-2016
411-350-0040	6-29-2016	Repeal	8-1-2016
411-350-0050	1-1-2016	Amend(T)	2-1-2016
411-350-0050	6-29-2016	Repeal	8-1-2016
411-350-0055	1-1-2016	Adopt(T)	2-1-2016
411-350-0075	6-29-2016	Repeal	8-1-2016
411-350-0080	1-1-2016	Amend(T)	2-1-2016
411-350-0080	6-29-2016	Repeal	8-1-2016
411-350-0085	6-29-2016	Repeal	8-1-2016
411-350-0100	1-1-2016	Amend(T)	2-1-2016
411-350-0100	6-29-2016	Repeal	8-1-2016
411-350-0110	6-29-2016	Repeal	8-1-2016
411-350-0115	6-29-2016	Repeal	8-1-2016
411-355-0000	12-28-2015	Amend	1-1-2016
411-355-0000	6-29-2016	Repeal	8-1-2016
411-355-0000(T)	12-28-2015	Repeal	1-1-2016
411-355-0010	12-28-2015	Amend	1-1-2016
411-355-0010	1-1-2016	Amend(T)	2-1-2016
411-355-0010	6-29-2016	Repeal	8-1-2016
411-355-0010(T)	12-28-2015	Repeal	1-1-2016
411-355-0020	12-28-2015	Amend	1-1-2016
411-355-0020	6-29-2016	Repeal	8-1-2016
411-355-0020(T)	12-28-2015	Repeal	1-1-2016
411-355-0030	12-28-2015	Amend	1-1-2016
411-355-0030	1-1-2016	Amend(T)	2-1-2016
411-355-0030	6-29-2016	Repeal	8-1-2016
411-355-0030(T)	12-28-2015	Repeal	1-1-2016
411-355-0040	12-28-2015	Amend	1-1-2016
411-355-0040	1-1-2016	Amend(T)	2-1-2016
411-355-0040	6-29-2016	Repeal	8-1-2016
411-355-0040(T)	12-28-2015	Repeal	1-1-2016
411-355-0045	12-28-2015	Adopt	1-1-2016
411-355-0045	6-29-2016	Repeal	8-1-2016
411-355-0045(T)	12-28-2015	Repeal	1-1-2016
411-355-0050	12-28-2015	Amend	1-1-2016
411-355-0050	1-1-2016	Amend(T)	2-1-2016
411-355-0050	6-29-2016	Repeal	8-1-2016
411-355-0050(T)	12-28-2015	Repeal	1-1-2016
411-355-0060	12-28-2015	Repeal	1-1-2016
411-355-0070	12-28-2015	Repeal	1-1-2016
411-355-0075	12-28-2015	Adopt	1-1-2016
411-355-0075	6-29-2016	Repeal	8-1-2016
411-355-0075(T)	12-28-2015	Repeal	1-1-2016
411-355-0080	12-28-2015	Amend	1-1-2016
411-355-0080	6-29-2016	Repeal	8-1-2016
411-355-0080(T)	12-28-2015	Repeal	1-1-2016
411-355-0090	12-28-2015	Amend	1-1-2016
411-355-0090	6-29-2016	Repeal	8-1-2016
411-355-0090(T)	12-28-2015	Repeal	1-1-2016
411-355-0100	12-28-2015	Amend	1-1-2016
411-355-0100	6-29-2016	Repeal	8-1-2016
411-355-0100(T)	12-28-2015	Repeal	1-1-2016
411-355-0110	12-28-2015	Repeal	1-1-2016
411-355-0120	12-28-2015	Repeal	1-1-2016
411-360-0010	1-1-2016	Amend(T)	2-1-2016
411-360-0010	6-29-2016	Amend	8-1-2016
411-360-0020	1-1-2016	Amend(T)	2-1-2016
411-360-0020	6-29-2016	Amend	8-1-2016
411-360-0050	1-1-2016	Amend(T)	2-1-2016
411-360-0050	6-29-2016	Amend	8-1-2016
411-360-0055	1-1-2016	Amend(T)	2-1-2016
411-360-0055	6-29-2016	Amend	8-1-2016
411-360-0060	1-1-2016	Amend(T)	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
411-360-0060	6-29-2016	Amend	8-1-2016
411-360-0110	6-29-2016	Amend	8-1-2016
411-360-0130	1-1-2016	Amend(T)	2-1-2016
411-360-0130	6-29-2016	Amend	8-1-2016
411-360-0140	1-1-2016	Amend(T)	2-1-2016
411-360-0140	6-29-2016	Amend	8-1-2016
411-360-0160	6-29-2016	Amend	8-1-2016
411-360-0170	1-1-2016	Amend(T)	2-1-2016
411-360-0170	6-29-2016	Amend	8-1-2016
411-360-0180	6-29-2016	Amend	8-1-2016
411-360-0190	1-1-2016	Amend(T)	2-1-2016
411-360-0190	6-29-2016	Amend	8-1-2016
411-360-0200	6-29-2016	Amend	8-1-2016
411-360-0260	6-29-2016	Amend	8-1-2016
411-370-0010	1-1-2016	Amend(T)	2-1-2016
411-370-0010	6-29-2016	Amend	8-1-2016
411-370-0020	6-29-2016	Amend	8-1-2016
411-370-0030	6-29-2016	Amend	8-1-2016
411-370-0040	6-29-2016	Amend	8-1-2016
411-375-0000	6-29-2016	Amend	8-1-2016
411-375-0010	1-1-2016	Amend(T)	2-1-2016
411-375-0010	6-29-2016	Amend	8-1-2016
411-375-0020	6-29-2016	Amend	8-1-2016
411-375-0030	6-29-2016	Repeal	8-1-2016
411-375-0035	6-29-2016	Adopt	8-1-2016
411-375-0040	6-29-2016	Amend	8-1-2016
411-375-0050	1-1-2016	Amend(T)	2-1-2016
411-375-0050	6-29-2016	Amend	8-1-2016
411-375-0055	1-1-2016	Adopt(T)	2-1-2016
411-375-0055	6-29-2016	Adopt	8-1-2016
411-375-0060	6-29-2016	Am. & Ren.	8-1-2016
411-375-0070	1-1-2016	Amend(T)	2-1-2016
411-375-0070	6-29-2016	Amend	8-1-2016
411-375-0080	1-1-2016	Amend(T)	2-1-2016
411-375-0080	6-29-2016	Amend	8-1-2016
411-380-0010	1-1-2016	Adopt(T)	2-1-2016
411-380-0010	6-29-2016	Adopt	8-1-2016
411-380-0020	1-1-2016	Adopt(T)	2-1-2016
411-380-0020	6-29-2016	Adopt	8-1-2016
411-380-0030	1-1-2016	Adopt(T)	2-1-2016
411-380-0030	6-29-2016	Adopt	8-1-2016
411-380-0040	1-1-2016	Adopt(T)	2-1-2016
411-380-0040	6-29-2016	Adopt	8-1-2016
411-380-0050	1-1-2016	Adopt(T)	2-1-2016
411-380-0050	6-29-2016	Adopt	8-1-2016
411-380-0060	1-1-2016	Adopt(T)	2-1-2016
411-380-0060	6-29-2016	Adopt	8-1-2016
411-380-0070	1-1-2016	Adopt(T)	2-1-2016
411-380-0070	6-29-2016	Adopt	8-1-2016
411-380-0080	1-1-2016	Adopt(T)	2-1-2016
411-380-0080	6-29-2016	Adopt	8-1-2016
411-380-0090	1-1-2016	Adopt(T)	2-1-2016
411-380-0090	6-29-2016	Adopt	8-1-2016
411-415-0010	6-29-2016	Adopt	8-1-2016
411-415-0020	6-29-2016	Adopt	8-1-2016
411-415-0030	6-29-2016	Adopt	8-1-2016
411-415-0040	6-29-2016	Adopt	8-1-2016
411-415-0050	6-29-2016	Adopt	8-1-2016
411-415-0060	6-29-2016	Adopt	8-1-2016
411-415-0070	6-29-2016	Adopt	8-1-2016
411-415-0080	6-29-2016	Adopt	8-1-2016
411-415-0090	6-29-2016	Adopt	8-1-2016
411-415-0100	6-29-2016	Adopt	8-1-2016
411-415-0110	6-29-2016	Adopt	8-1-2016
411-415-0120	6-29-2016	Adopt	8-1-2016
411-435-0010	6-29-2016	Adopt	8-1-2016
411-435-0020	6-29-2016	Adopt	8-1-2016
411-435-0030	6-29-2016	Adopt	8-1-2016
411-435-0040	6-29-2016	Adopt	8-1-2016
411-435-0050	6-29-2016	Adopt	8-1-2016
411-435-0060	6-29-2016	Adopt	8-1-2016
411-435-0070	6-29-2016	Adopt	8-1-2016
411-435-0080	6-29-2016	Adopt	8-1-2016
411-450-0010	6-29-2016	Adopt	8-1-2016
411-450-0020	6-29-2016	Adopt	8-1-2016
411-450-0030	6-29-2016	Adopt	8-1-2016
411-450-0040	6-29-2016	Adopt	8-1-2016
411-450-0050	6-29-2016	Adopt	8-1-2016
411-450-0060	6-29-2016	Adopt	8-1-2016
411-450-0070	6-29-2016	Adopt	8-1-2016
411-450-0080	6-29-2016	Adopt	8-1-2016
411-450-0100	6-29-2016	Adopt	8-1-2016
413-010-0000	2-1-2016	Amend	3-1-2016
413-010-0035	2-1-2016	Amend	3-1-2016
413-010-0180	5-17-2016	Amend(T)	7-1-2016
413-015-0100	7-1-2016	Amend(T)	8-1-2016
413-015-0115	1-1-2016	Amend	2-1-2016
413-015-0115	7-1-2016	Amend(T)	8-1-2016
413-015-0115(T)	1-1-2016	Repeal	2-1-2016
413-015-0125	7-1-2016	Amend(T)	8-1-2016
413-015-0205	1-1-2016	Amend	2-1-2016
413-015-0205	7-1-2016	Amend(T)	8-1-2016
413-015-0210	7-1-2016	Amend(T)	8-1-2016
413-015-0211	1-1-2016	Amend	2-1-2016
413-015-0211	7-1-2016	Amend(T)	8-1-2016
413-015-0211(T)	1-1-2016	Repeal	2-1-2016
413-015-0212	7-1-2016	Amend(T)	8-1-2016
413-015-0215	4-11-2016	Amend(T)	5-1-2016
413-015-0215	7-1-2016	Amend(T)	8-1-2016
413-015-0215(T)	7-1-2016	Suspend	8-1-2016
413-015-0300	7-1-2016	Amend(T)	8-1-2016
413-015-0409	7-1-2016	Amend(T)	8-1-2016
413-015-0415	1-1-2016	Amend	2-1-2016
413-015-0415	7-1-2016	Amend(T)	8-1-2016
413-015-0415(T)	1-1-2016	Repeal	2-1-2016
413-015-0420	7-1-2016	Amend(T)	8-1-2016
413-015-0440	7-1-2016	Amend(T)	8-1-2016
413-015-0445	7-1-2016	Amend(T)	8-1-2016
413-015-0450	7-1-2016	Amend(T)	8-1-2016
413-015-0460	1-1-2016	Amend	2-1-2016
413-015-0470	1-1-2016	Amend	2-1-2016
413-015-0470	7-1-2016	Amend(T)	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
413-015-0620	7-1-2016	Adopt(T)	8-1-2016
413-015-0625	7-1-2016	Adopt(T)	8-1-2016
413-015-0630	7-1-2016	Adopt(T)	8-1-2016
413-015-0640	7-1-2016	Adopt(T)	8-1-2016
413-015-1000	7-1-2016	Amend(T)	8-1-2016
413-015-1220	1-1-2016	Amend	2-1-2016
413-015-9000	1-1-2016	Amend	2-1-2016
413-015-9000(T)	1-1-2016	Repeal	2-1-2016
413-015-9030	7-1-2016	Amend(T)	8-1-2016
413-015-9040	7-1-2016	Amend(T)	8-1-2016
413-030-0400	11-24-2015	Amend(T)	1-1-2016
413-030-0400	2-1-2016	Amend	3-1-2016
413-030-0400(T)	2-1-2016	Repeal	3-1-2016
413-040-0000	1-1-2016	Amend(T)	2-1-2016
413-040-0000	6-1-2016	Amend	7-1-2016
413-040-0000(T)	6-1-2016	Repeal	7-1-2016
413-040-0010	11-24-2015	Amend(T)	1-1-2016
413-040-0010	2-1-2016	Amend	3-1-2016
413-040-0010(T)	2-1-2016	Repeal	3-1-2016
413-040-0013	5-17-2016	Amend(T)	7-1-2016
413-040-0145	1-1-2016	Amend(T)	2-1-2016
413-040-0145	6-1-2016	Amend	7-1-2016
413-040-0145(T)	6-1-2016	Repeal	7-1-2016
413-040-0150	1-1-2016	Amend(T)	2-1-2016
413-040-0150	6-1-2016	Amend	7-1-2016
413-040-0150(T)	6-1-2016	Repeal	7-1-2016
413-070-0551	11-24-2015	Amend(T)	1-1-2016
413-070-0551	2-1-2016	Amend	3-1-2016
413-070-0551(T)	2-1-2016	Repeal	3-1-2016
413-080-0050	11-24-2015	Amend(T)	1-1-2016
413-080-0050	1-1-2016	Amend	2-1-2016
413-080-0050	7-1-2016	Amend(T)	8-1-2016
413-080-0050(T)	11-24-2015	Suspend	1-1-2016
413-080-0050(T)	1-1-2016	Repeal	2-1-2016
413-080-0051	7-1-2016	Adopt(T)	8-1-2016
413-080-0052	7-1-2016	Amend(T)	8-1-2016
413-080-0053	1-1-2016	Adopt	2-1-2016
413-080-0053(T)	1-1-2016	Repeal	2-1-2016
413-080-0054	1-1-2016	Amend	2-1-2016
413-080-0054	7-1-2016	Amend(T)	8-1-2016
413-080-0054(T)	1-1-2016	Repeal	2-1-2016
413-080-0059	7-1-2016	Amend(T)	8-1-2016
413-080-0070	7-1-2016	Adopt(T)	8-1-2016
413-090-0000	7-1-2016	Amend(T)	8-1-2016
413-090-0055	7-1-2016	Amend(T)	8-1-2016
413-090-0065	7-1-2016	Amend(T)	8-1-2016
413-090-0070	7-1-2016	Amend(T)	8-1-2016
413-090-0075	7-1-2016	Amend(T)	8-1-2016
413-090-0080	7-1-2016	Amend(T)	8-1-2016
413-090-0085	1-1-2016	Amend	2-1-2016
413-090-0085	6-14-2016	Amend(T)	7-1-2016
413-090-0085(T)	1-1-2016	Repeal	2-1-2016
413-090-0087	1-1-2016	Adopt	2-1-2016
413-090-0087	7-1-2016	Amend(T)	8-1-2016
413-090-0087(T)	1-1-2016	Repeal	2-1-2016
413-090-0090	7-1-2016	Amend(T)	8-1-2016
413-090-0400	2-1-2016	Amend	3-1-2016
413-090-0410	2-1-2016	Repeal	3-1-2016
413-090-0420	2-1-2016	Repeal	3-1-2016
413-090-0430	2-1-2016	Repeal	3-1-2016
413-090-0500	6-1-2016	Repeal	7-1-2016
413-090-0510	6-1-2016	Repeal	7-1-2016
413-090-0520	6-1-2016	Repeal	7-1-2016
413-090-0530	6-1-2016	Repeal	7-1-2016
413-090-0540	6-1-2016	Repeal	7-1-2016
413-090-0550	6-1-2016	Repeal	7-1-2016
413-100-0400	12-21-2015	Amend	2-1-2016
413-100-0410	12-21-2015	Amend	2-1-2016
413-100-0420	12-21-2015	Amend	2-1-2016
413-100-0435	12-21-2015	Amend	2-1-2016
413-100-0457	12-21-2015	Repeal	2-1-2016
413-100-0800	4-1-2016	Amend	5-1-2016
413-100-0810	4-1-2016	Amend	5-1-2016
413-100-0820	4-1-2016	Amend	5-1-2016
413-100-0830	4-1-2016	Amend	5-1-2016
413-100-0840	4-1-2016	Repeal	5-1-2016
413-100-0850	4-1-2016	Repeal	5-1-2016
413-120-0000	6-1-2016	Amend	7-1-2016
413-120-0025	6-1-2016	Amend	7-1-2016
413-120-0730	2-24-2016	Amend(T)	4-1-2016
413-120-0730	6-1-2016	Amend	7-1-2016
413-120-0730(T)	6-1-2016	Repeal	7-1-2016
413-120-0925	1-1-2016	Amend(T)	2-1-2016
413-120-0925	6-1-2016	Amend	7-1-2016
413-120-0925(T)	6-1-2016	Repeal	7-1-2016
413-130-0000	1-1-2016	Amend(T)	2-1-2016
413-130-0000	6-29-2016	Amend	8-1-2016
413-130-0300	1-1-2016	Amend(T)	2-1-2016
413-130-0300	6-29-2016	Amend	8-1-2016
413-130-0310	1-1-2016	Amend(T)	2-1-2016
413-130-0310	6-29-2016	Amend	8-1-2016
413-130-0320	1-1-2016	Amend(T)	2-1-2016
413-130-0320	6-29-2016	Amend	8-1-2016
413-130-0330	1-1-2016	Amend(T)	2-1-2016
413-130-0330	6-29-2016	Amend	8-1-2016
413-130-0340	1-1-2016	Amend(T)	2-1-2016
413-130-0340	6-29-2016	Amend	8-1-2016
413-130-0350	1-1-2016	Amend(T)	2-1-2016
413-130-0350	6-29-2016	Amend	8-1-2016
413-130-0355	1-1-2016	Amend(T)	2-1-2016
413-130-0355	6-29-2016	Amend	8-1-2016
413-130-0360	1-1-2016	Amend(T)	2-1-2016
413-130-0360	6-29-2016	Amend	8-1-2016
413-130-0365	1-1-2016	Adopt(T)	2-1-2016
413-130-0365	6-29-2016	Adopt	8-1-2016
413-130-0400	1-1-2016	Suspend	2-1-2016
413-130-0400	6-29-2016	Repeal	8-1-2016
413-130-0420	1-1-2016	Suspend	2-1-2016
413-130-0420	6-29-2016	Repeal	8-1-2016
413-130-0430	1-1-2016	Suspend	2-1-2016
413-130-0430	6-29-2016	Repeal	8-1-2016
413-130-0440	1-1-2016	Suspend	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
413-130-0440	6-29-2016	Repeal	8-1-2016
413-130-0450	1-1-2016	Suspend	2-1-2016
413-130-0450	6-29-2016	Repeal	8-1-2016
413-130-0455	1-1-2016	Suspend	2-1-2016
413-130-0455	6-29-2016	Repeal	8-1-2016
413-130-0460	1-1-2016	Suspend	2-1-2016
413-130-0460	6-29-2016	Repeal	8-1-2016
413-130-0480	1-1-2016	Suspend	2-1-2016
413-130-0480	6-29-2016	Repeal	8-1-2016
413-130-0490	1-1-2016	Suspend	2-1-2016
413-130-0490	6-29-2016	Repeal	8-1-2016
413-130-0500	1-1-2016	Suspend	2-1-2016
413-130-0500	6-29-2016	Repeal	8-1-2016
413-130-0510	1-1-2016	Suspend	2-1-2016
413-130-0510	6-29-2016	Repeal	8-1-2016
413-130-0520	1-1-2016	Suspend	2-1-2016
413-130-0520	6-29-2016	Repeal	8-1-2016
413-140-0032	4-26-2016	Amend(T)	6-1-2016
413-215-0000	7-1-2016	Adopt(T)	8-1-2016
413-215-0001	7-1-2016	Amend(T)	8-1-2016
413-215-0006	7-1-2016	Suspend	8-1-2016
413-215-0011	7-1-2016	Amend(T)	8-1-2016
413-215-0016	7-1-2016	Amend(T)	8-1-2016
413-215-0021	7-1-2016	Amend(T)	8-1-2016
413-215-0026	7-1-2016	Amend(T)	8-1-2016
413-215-0031	7-1-2016	Amend(T)	8-1-2016
413-215-0036	7-1-2016	Amend(T)	8-1-2016
413-215-0041	7-1-2016	Amend(T)	8-1-2016
413-215-0046	7-1-2016	Amend(T)	8-1-2016
413-215-0051	7-1-2016	Amend(T)	8-1-2016
413-215-0056	7-1-2016	Amend(T)	8-1-2016
413-215-0061	7-1-2016	Amend(T)	8-1-2016
413-215-0066	7-1-2016	Amend(T)	8-1-2016
413-215-0071	7-1-2016	Amend(T)	8-1-2016
413-215-0076	7-1-2016	Amend(T)	8-1-2016
413-215-0081	7-1-2016	Amend(T)	8-1-2016
413-215-0086	7-1-2016	Amend(T)	8-1-2016
413-215-0091	7-1-2016	Amend(T)	8-1-2016
413-215-0096	7-1-2016	Amend(T)	8-1-2016
413-215-0101	7-1-2016	Amend(T)	8-1-2016
413-215-0106	7-1-2016	Amend(T)	8-1-2016
413-215-0111	7-1-2016	Amend(T)	8-1-2016
413-215-0116	7-1-2016	Amend(T)	8-1-2016
413-215-0121	7-1-2016	Amend(T)	8-1-2016
413-215-0126	7-1-2016	Amend(T)	8-1-2016
413-215-0131	7-1-2016	Amend(T)	8-1-2016
413-215-0201	7-1-2016	Amend(T)	8-1-2016
413-215-0206	7-1-2016	Suspend	8-1-2016
413-215-0211	7-1-2016	Amend(T)	8-1-2016
413-215-0216	7-1-2016	Amend(T)	8-1-2016
413-215-0221	7-1-2016	Amend(T)	8-1-2016
413-215-0226	7-1-2016	Amend(T)	8-1-2016
413-215-0231	7-1-2016	Amend(T)	8-1-2016
413-215-0236	7-1-2016	Amend(T)	8-1-2016
413-215-0241	7-1-2016	Amend(T)	8-1-2016
413-215-0246	7-1-2016	Amend(T)	8-1-2016
413-215-0251	7-1-2016	Amend(T)	8-1-2016
413-215-0256	7-1-2016	Suspend	8-1-2016
413-215-0261	7-1-2016	Amend(T)	8-1-2016
413-215-0266	7-1-2016	Amend(T)	8-1-2016
413-215-0271	7-1-2016	Amend(T)	8-1-2016
413-215-0276	7-1-2016	Amend(T)	8-1-2016
413-215-0301	7-1-2016	Amend(T)	8-1-2016
413-215-0306	7-1-2016	Suspend	8-1-2016
413-215-0311	7-1-2016	Amend(T)	8-1-2016
413-215-0313	7-1-2016	Amend(T)	8-1-2016
413-215-0316	7-1-2016	Amend(T)	8-1-2016
413-215-0321	7-1-2016	Amend(T)	8-1-2016
413-215-0326	7-1-2016	Amend(T)	8-1-2016
413-215-0331	7-1-2016	Amend(T)	8-1-2016
413-215-0336	7-1-2016	Amend(T)	8-1-2016
413-215-0341	7-1-2016	Amend(T)	8-1-2016
413-215-0346	7-1-2016	Suspend	8-1-2016
413-215-0349	7-1-2016	Amend(T)	8-1-2016
413-215-0351	7-1-2016	Amend(T)	8-1-2016
413-215-0356	7-1-2016	Amend(T)	8-1-2016
413-215-0361	7-1-2016	Amend(T)	8-1-2016
413-215-0366	7-1-2016	Amend(T)	8-1-2016
413-215-0371	7-1-2016	Amend(T)	8-1-2016
413-215-0376	7-1-2016	Amend(T)	8-1-2016
413-215-0381	7-1-2016	Amend(T)	8-1-2016
413-215-0386	7-1-2016	Amend(T)	8-1-2016
413-215-0391	7-1-2016	Amend(T)	8-1-2016
413-215-0396	7-1-2016	Amend(T)	8-1-2016
413-215-0401	7-1-2016	Amend(T)	8-1-2016
413-215-0406	7-1-2016	Suspend	8-1-2016
413-215-0411	7-1-2016	Amend(T)	8-1-2016
413-215-0416	7-1-2016	Amend(T)	8-1-2016
413-215-0421	7-1-2016	Amend(T)	8-1-2016
413-215-0426	7-1-2016	Amend(T)	8-1-2016
413-215-0431	7-1-2016	Amend(T)	8-1-2016
413-215-0436	7-1-2016	Amend(T)	8-1-2016
413-215-0441	7-1-2016	Amend(T)	8-1-2016
413-215-0446	7-1-2016	Amend(T)	8-1-2016
413-215-0451	7-1-2016	Amend(T)	8-1-2016
413-215-0456	7-1-2016	Amend(T)	8-1-2016
413-215-0461	7-1-2016	Amend(T)	8-1-2016
413-215-0466	7-1-2016	Amend(T)	8-1-2016
413-215-0471	7-1-2016	Amend(T)	8-1-2016
413-215-0476	7-1-2016	Amend(T)	8-1-2016
413-215-0481	7-1-2016	Amend(T)	8-1-2016
413-215-0501	7-1-2016	Amend(T)	8-1-2016
413-215-0506	7-1-2016	Suspend	8-1-2016
413-215-0511	7-1-2016	Amend(T)	8-1-2016
413-215-0516	7-1-2016	Amend(T)	8-1-2016
413-215-0521	7-1-2016	Amend(T)	8-1-2016
413-215-0526	7-1-2016	Amend(T)	8-1-2016
413-215-0531	7-1-2016	Amend(T)	8-1-2016
413-215-0536	7-1-2016	Amend(T)	8-1-2016
413-215-0541	7-1-2016	Amend(T)	8-1-2016
413-215-0546	7-1-2016	Amend(T)	8-1-2016
413-215-0551	7-1-2016	Amend(T)	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
413-215-0554	7-1-2016	Amend(T)	8-1-2016
413-215-0556	7-1-2016	Amend(T)	8-1-2016
413-215-0561	7-1-2016	Amend(T)	8-1-2016
413-215-0566	7-1-2016	Amend(T)	8-1-2016
413-215-0571	7-1-2016	Amend(T)	8-1-2016
413-215-0576	7-1-2016	Amend(T)	8-1-2016
413-215-0581	7-1-2016	Amend(T)	8-1-2016
413-215-0586	7-1-2016	Amend(T)	8-1-2016
413-215-0601	7-1-2016	Amend(T)	8-1-2016
413-215-0606	7-1-2016	Suspend	8-1-2016
413-215-0611	7-1-2016	Amend(T)	8-1-2016
413-215-0616	7-1-2016	Amend(T)	8-1-2016
413-215-0621	7-1-2016	Amend(T)	8-1-2016
413-215-0626	7-1-2016	Amend(T)	8-1-2016
413-215-0631	7-1-2016	Amend(T)	8-1-2016
413-215-0636	7-1-2016	Amend(T)	8-1-2016
413-215-0641	7-1-2016	Amend(T)	8-1-2016
413-215-0646	7-1-2016	Amend(T)	8-1-2016
413-215-0651	7-1-2016	Amend(T)	8-1-2016
413-215-0656	7-1-2016	Amend(T)	8-1-2016
413-215-0661	7-1-2016	Amend(T)	8-1-2016
413-215-0666	7-1-2016	Amend(T)	8-1-2016
413-215-0671	7-1-2016	Amend(T)	8-1-2016
413-215-0676	7-1-2016	Amend(T)	8-1-2016
413-215-0681	7-1-2016	Amend(T)	8-1-2016
413-215-0701	7-1-2016	Amend(T)	8-1-2016
413-215-0706	7-1-2016	Suspend	8-1-2016
413-215-0711	7-1-2016	Amend(T)	8-1-2016
413-215-0716	7-1-2016	Amend(T)	8-1-2016
413-215-0721	7-1-2016	Amend(T)	8-1-2016
413-215-0726	7-1-2016	Amend(T)	8-1-2016
413-215-0731	7-1-2016	Amend(T)	8-1-2016
413-215-0736	7-1-2016	Amend(T)	8-1-2016
413-215-0741	7-1-2016	Amend(T)	8-1-2016
413-215-0746	7-1-2016	Amend(T)	8-1-2016
413-215-0751	7-1-2016	Amend(T)	8-1-2016
413-215-0756	7-1-2016	Amend(T)	8-1-2016
413-215-0761	7-1-2016	Amend(T)	8-1-2016
413-215-0766	7-1-2016	Amend(T)	8-1-2016
413-215-0801	7-1-2016	Amend(T)	8-1-2016
413-215-0806	7-1-2016	Suspend	8-1-2016
413-215-0811	7-1-2016	Amend(T)	8-1-2016
413-215-0816	7-1-2016	Amend(T)	8-1-2016
413-215-0821	7-1-2016	Amend(T)	8-1-2016
413-215-0826	7-1-2016	Amend(T)	8-1-2016
413-215-0831	7-1-2016	Amend(T)	8-1-2016
413-215-0836	7-1-2016	Amend(T)	8-1-2016
413-215-0841	7-1-2016	Amend(T)	8-1-2016
413-215-0846	7-1-2016	Amend(T)	8-1-2016
413-215-0851	7-1-2016	Amend(T)	8-1-2016
413-215-0856	7-1-2016	Amend(T)	8-1-2016
413-215-0901	7-1-2016	Amend(T)	8-1-2016
413-215-0906	7-1-2016	Suspend	8-1-2016
413-215-0911	7-1-2016	Suspend	8-1-2016
413-215-0916	7-1-2016	Amend(T)	8-1-2016
413-215-0918	7-1-2016	Amend(T)	8-1-2016
413-215-0921	7-1-2016	Amend(T)	8-1-2016
413-215-0926	7-1-2016	Amend(T)	8-1-2016
413-215-0931	7-1-2016	Amend(T)	8-1-2016
413-215-0936	7-1-2016	Amend(T)	8-1-2016
413-215-0941	7-1-2016	Amend(T)	8-1-2016
413-215-0946	7-1-2016	Amend(T)	8-1-2016
413-215-0951	7-1-2016	Amend(T)	8-1-2016
413-215-0956	7-1-2016	Amend(T)	8-1-2016
413-215-0961	7-1-2016	Amend(T)	8-1-2016
413-215-0966	7-1-2016	Amend(T)	8-1-2016
413-215-0971	7-1-2016	Amend(T)	8-1-2016
413-215-0976	7-1-2016	Amend(T)	8-1-2016
413-215-0981	7-1-2016	Amend(T)	8-1-2016
413-215-0986	7-1-2016	Amend(T)	8-1-2016
413-215-0991	7-1-2016	Amend(T)	8-1-2016
413-215-0992	7-1-2016	Amend(T)	8-1-2016
413-215-0996	7-1-2016	Amend(T)	8-1-2016
413-215-1001	7-1-2016	Amend(T)	8-1-2016
413-215-1006	7-1-2016	Amend(T)	8-1-2016
413-215-1011	7-1-2016	Amend(T)	8-1-2016
413-215-1016	7-1-2016	Amend(T)	8-1-2016
413-215-1021	7-1-2016	Amend(T)	8-1-2016
413-215-1026	7-1-2016	Amend(T)	8-1-2016
413-215-1031	7-1-2016	Amend(T)	8-1-2016
414-150-0050	1-25-2016	Amend	3-1-2016
414-150-0055	1-25-2016	Amend	3-1-2016
414-150-0060	1-25-2016	Amend	3-1-2016
414-150-0070	1-25-2016	Amend	3-1-2016
414-150-0080	1-25-2016	Repeal	3-1-2016
414-150-0090	1-25-2016	Repeal	3-1-2016
414-150-0100	1-25-2016	Repeal	3-1-2016
414-150-0110	1-25-2016	Amend	3-1-2016
414-150-0120	1-25-2016	Amend	3-1-2016
414-150-0130	1-25-2016	Amend	3-1-2016
414-150-0140	1-25-2016	Adopt	3-1-2016
414-150-0150	1-25-2016	Adopt	3-1-2016
414-150-0160	1-25-2016	Adopt	3-1-2016
414-150-0170	1-25-2016	Adopt	3-1-2016
414-180-0005	6-29-2016	Adopt	8-1-2016
414-180-0010	6-29-2016	Adopt	8-1-2016
414-180-0015	6-29-2016	Adopt	8-1-2016
414-180-0020	6-29-2016	Adopt	8-1-2016
414-180-0025	6-29-2016	Adopt	8-1-2016
414-180-0030	6-29-2016	Adopt	8-1-2016
414-180-0035	6-29-2016	Adopt	8-1-2016
414-180-0040	6-29-2016	Adopt	8-1-2016
414-180-0045	6-29-2016	Adopt	8-1-2016
414-180-0050	6-29-2016	Adopt	8-1-2016
414-180-0055	6-29-2016	Adopt	8-1-2016
414-180-0090	6-29-2016	Adopt	8-1-2016
414-180-0100	6-29-2016	Adopt	8-1-2016
415-012-0000	7-1-2016	Amend(T)	8-1-2016
415-012-0010	7-1-2016	Amend(T)	8-1-2016
415-012-0020	7-1-2016	Amend(T)	8-1-2016
415-012-0030	7-1-2016	Amend(T)	8-1-2016
415-012-0035	7-1-2016	Amend(T)	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
415-012-0040	7-1-2016	Amend(T)	8-1-2016
415-012-0050	7-1-2016	Amend(T)	8-1-2016
415-012-0055	7-1-2016	Amend(T)	8-1-2016
415-012-0060	7-1-2016	Amend(T)	8-1-2016
415-012-0065	7-1-2016	Amend(T)	8-1-2016
415-012-0067	7-1-2016	Amend(T)	8-1-2016
415-012-0070	7-1-2016	Amend(T)	8-1-2016
415-012-0090	7-1-2016	Amend(T)	8-1-2016
415-060-0010	1-5-2016	Suspend	2-1-2016
415-060-0010	7-13-2016	Repeal	8-1-2016
415-060-0020	1-5-2016	Suspend	2-1-2016
415-060-0020	7-13-2016	Repeal	8-1-2016
415-060-0030	1-5-2016	Suspend	2-1-2016
415-060-0030	7-13-2016	Repeal	8-1-2016
415-060-0040	1-5-2016	Suspend	2-1-2016
415-060-0040	7-13-2016	Repeal	8-1-2016
415-060-0050	1-5-2016	Suspend	2-1-2016
415-060-0050	7-13-2016	Repeal	8-1-2016
416-115-0025	4-1-2016	Amend	5-1-2016
416-335-0090	3-10-2016	Amend(T)	4-1-2016
416-335-0090	5-2-2016	Amend	6-1-2016
416-335-0090	6-3-2016	Amend(T)	7-1-2016
416-530-0010	3-2-2016	Amend	4-1-2016
416-530-0020	3-2-2016	Amend	4-1-2016
416-530-0030	3-2-2016	Amend	4-1-2016
416-530-0035	3-2-2016	Amend	4-1-2016
416-530-0040	3-2-2016	Amend	4-1-2016
416-530-0060	3-2-2016	Amend	4-1-2016
416-530-0070	3-2-2016	Amend	4-1-2016
416-530-0090	3-2-2016	Amend	4-1-2016
416-530-0200	3-2-2016	Amend	4-1-2016
418-040-0000	1-1-2016	Adopt(T)	2-1-2016
418-040-0000	6-20-2016	Adopt	7-1-2016
418-040-0000(T)	6-20-2016	Repeal	7-1-2016
418-040-0010	1-1-2016	Adopt(T)	2-1-2016
418-040-0010	6-20-2016	Adopt	7-1-2016
418-040-0010(T)	6-20-2016	Repeal	7-1-2016
418-040-0020	1-1-2016	Adopt(T)	2-1-2016
418-040-0020	6-20-2016	Adopt	7-1-2016
418-040-0020(T)	6-20-2016	Repeal	7-1-2016
418-040-0030	1-1-2016	Adopt(T)	2-1-2016
418-040-0030	6-20-2016	Adopt	7-1-2016
418-040-0030(T)	6-20-2016	Repeal	7-1-2016
418-040-0040	1-1-2016	Adopt(T)	2-1-2016
418-040-0040	6-20-2016	Adopt	7-1-2016
418-040-0040(T)	6-20-2016	Repeal	7-1-2016
418-040-0050	1-1-2016	Adopt(T)	2-1-2016
418-040-0050	6-20-2016	Adopt	7-1-2016
418-040-0050(T)	6-20-2016	Repeal	7-1-2016
418-040-0060	1-1-2016	Adopt(T)	2-1-2016
418-040-0060	6-20-2016	Adopt	7-1-2016
418-040-0060(T)	6-20-2016	Repeal	7-1-2016
418-040-0070	1-1-2016	Adopt(T)	2-1-2016
418-040-0070	6-20-2016	Adopt	7-1-2016
418-040-0070(T)	6-20-2016	Repeal	7-1-2016
418-040-0080	1-1-2016	Adopt(T)	2-1-2016
418-040-0080	6-20-2016	Adopt	7-1-2016
418-040-0080(T)	6-20-2016	Repeal	7-1-2016
418-040-0090	1-1-2016	Adopt(T)	2-1-2016
418-040-0090	6-20-2016	Adopt	7-1-2016
418-040-0090(T)	6-20-2016	Repeal	7-1-2016
431-121-2005	12-7-2015	Amend	1-1-2016
436-001-0003	1-1-2016	Amend	1-1-2016
436-001-0004	1-1-2016	Amend	1-1-2016
436-001-0009	1-1-2016	Amend	1-1-2016
436-001-0019	1-1-2016	Amend	1-1-2016
436-001-0027	1-1-2016	Amend	1-1-2016
436-001-0030	1-1-2016	Amend	1-1-2016
436-001-0170	1-1-2016	Amend	1-1-2016
436-001-0240	1-1-2016	Amend	1-1-2016
436-001-0246	1-1-2016	Amend	1-1-2016
436-001-0259	1-1-2016	Amend	1-1-2016
436-001-0410	1-1-2016	Amend	1-1-2016
436-001-0420	1-1-2016	Amend	1-1-2016
436-001-0435	1-1-2016	Adopt	1-1-2016
436-001-0500	1-1-2016	Adopt	1-1-2016
436-009-0001	4-1-2016	Amend	4-1-2016
436-009-0004	1-1-2016	Amend(T)	1-1-2016
436-009-0004	4-1-2016	Amend	4-1-2016
436-009-0004(T)	4-1-2016	Repeal	4-1-2016
436-009-0005	4-1-2016	Amend	4-1-2016
436-009-0008	4-1-2016	Amend	4-1-2016
436-009-0010	1-1-2016	Amend(T)	1-1-2016
436-009-0010	4-1-2016	Amend	4-1-2016
436-009-0010(T)	4-1-2016	Repeal	4-1-2016
436-009-0020	4-1-2016	Amend	4-1-2016
436-009-0025	4-1-2016	Amend	4-1-2016
436-009-0030	4-1-2016	Amend	4-1-2016
436-009-0040	4-1-2016	Amend	4-1-2016
436-009-0060	4-1-2016	Amend	4-1-2016
436-009-0080	4-1-2016	Amend	4-1-2016
436-009-0090	4-1-2016	Amend	4-1-2016
436-009-0110	4-1-2016	Amend	4-1-2016
436-010-0001	4-1-2016	Amend	4-1-2016
436-010-0005	4-1-2016	Amend	4-1-2016
436-010-0008	4-1-2016	Amend	4-1-2016
436-010-0240	4-1-2016	Amend	4-1-2016
436-010-0265	4-1-2016	Amend	4-1-2016
436-010-0270	4-1-2016	Amend	4-1-2016
436-010-0330	4-1-2016	Amend	4-1-2016
436-010-0340	4-1-2016	Amend	4-1-2016
436-050-0003	1-1-2016	Amend	2-1-2016
436-050-0175	1-1-2016	Amend	2-1-2016
437-003-0001	1-1-2017	Amend	4-1-2016
437-003-0134	1-1-2017	Amend	4-1-2016
437-003-0503	10-1-2017	Amend	4-1-2016
437-003-1500	10-1-2017	Amend	4-1-2016
437-003-1501	1-1-2017	Amend	4-1-2016
437-003-2501	1-1-2017	Adopt	4-1-2016
437-003-3502	10-1-2017	Repeal	4-1-2016
438-005-0035	1-1-2016	Amend	2-1-2016
438-015-0010	1-1-2016	Amend	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
438-015-0019	1-1-2016	Amend	2-1-2016
438-015-0025	1-1-2016	Amend	2-1-2016
438-015-0033	1-1-2016	Adopt	2-1-2016
438-015-0045	1-1-2016	Amend	2-1-2016
438-015-0048	1-1-2016	Adopt	2-1-2016
438-015-0055	1-1-2016	Amend	2-1-2016
438-015-0065	1-1-2016	Amend	2-1-2016
438-015-0070	1-1-2016	Amend	2-1-2016
438-015-0110	1-1-2016	Amend	2-1-2016
440-001-9000	1-1-2016	Adopt(T)	2-1-2016
440-001-9001	6-29-2016	Adopt(T)	8-1-2016
441-175-0002	3-7-2016	Amend	4-1-2016
441-175-0010	3-7-2016	Amend	4-1-2016
441-175-0015	3-7-2016	Amend	4-1-2016
441-175-0020	3-7-2016	Amend	4-1-2016
441-175-0030	3-7-2016	Amend	4-1-2016
441-175-0040	3-7-2016	Amend	4-1-2016
441-175-0041	3-7-2016	Amend	4-1-2016
441-175-0046	3-7-2016	Amend	4-1-2016
441-175-0050	3-7-2016	Amend	4-1-2016
441-175-0055	3-7-2016	Amend	4-1-2016
441-175-0060	3-7-2016	Amend	4-1-2016
441-175-0070	3-7-2016	Amend	4-1-2016
441-175-0085	3-7-2016	Amend	4-1-2016
441-175-0100	3-7-2016	Amend	4-1-2016
441-175-0110	3-7-2016	Amend	4-1-2016
441-175-0120	3-7-2016	Amend	4-1-2016
441-175-0130	3-7-2016	Amend	4-1-2016
441-175-0140	3-7-2016	Amend	4-1-2016
441-175-0150	3-7-2016	Amend	4-1-2016
441-175-0160	3-7-2016	Amend	4-1-2016
441-175-0165	3-7-2016	Amend	4-1-2016
441-175-0171	3-7-2016	Amend	4-1-2016
441-175-0175	3-7-2016	Amend	4-1-2016
441-500-0020	3-16-2016	Amend(T)	5-1-2016
441-710-0305	1-1-2016	Adopt	2-1-2016
441-855-0114	1-1-2016	Adopt	1-1-2016
441-865-0060	12-14-2015	Amend	1-1-2016
459-001-0000	1-29-2016	Amend	3-1-2016
459-005-0001	11-20-2015	Amend	1-1-2016
459-005-0001	5-27-2016	Amend	7-1-2016
459-005-0310	11-20-2015	Amend	1-1-2016
459-005-0350	11-20-2015	Amend	1-1-2016
459-005-0605	1-29-2016	Adopt	3-1-2016
459-010-0012	11-20-2015	Amend	1-1-2016
459-011-0500	11-20-2015	Amend	1-1-2016
459-013-0060	11-20-2015	Amend	1-1-2016
459-013-0310	11-20-2015	Amend	1-1-2016
459-075-0020	5-27-2016	Amend	7-1-2016
459-080-0020	5-27-2016	Amend	7-1-2016
459-080-0150	1-1-2016	Amend	1-1-2016
461-001-0000	1-1-2016	Amend	2-1-2016
461-001-0000	4-1-2016	Amend	5-1-2016
461-001-0000	7-1-2016	Amend(T)	8-1-2016
461-001-0000(T)	1-1-2016	Repeal	2-1-2016
461-001-0020	4-1-2016	Amend	5-1-2016
461-001-0025	12-28-2015	Amend	2-1-2016
461-001-0025	4-1-2016	Amend	5-1-2016
461-101-0010	7-1-2016	Amend(T)	8-1-2016
461-110-0210	4-1-2016	Amend	5-1-2016
461-110-0390	7-1-2016	Suspend	8-1-2016
461-110-0630	4-1-2016	Amend	5-1-2016
461-110-0630	7-1-2016	Amend(T)	8-1-2016
461-110-0750	4-1-2016	Amend	5-1-2016
461-110-0750	7-1-2016	Amend(T)	8-1-2016
461-115-0016	1-1-2016	Amend(T)	2-1-2016
461-115-0016	4-1-2016	Amend	5-1-2016
461-115-0016(T)	4-1-2016	Repeal	5-1-2016
461-115-0030	7-1-2016	Amend(T)	8-1-2016
461-115-0050	7-1-2016	Amend(T)	8-1-2016
461-115-0071	7-1-2016	Amend(T)	8-1-2016
461-115-0430	7-1-2016	Amend(T)	8-1-2016
461-115-0651	1-1-2016	Amend	2-1-2016
461-115-0700	1-1-2016	Amend	2-1-2016
461-115-0700	7-1-2016	Amend(T)	8-1-2016
461-120-0030	7-1-2016	Amend(T)	8-1-2016
461-120-0110	3-4-2016	Amend(T)	4-1-2016
461-120-0110	5-1-2016	Amend	6-1-2016
461-120-0110(T)	5-1-2016	Repeal	6-1-2016
461-120-0125	1-1-2016	Amend	2-1-2016
461-120-0125	7-1-2016	Amend(T)	8-1-2016
461-120-0210	4-1-2016	Amend	5-1-2016
461-120-0210	7-1-2016	Amend(T)	8-1-2016
461-120-0315	7-1-2016	Amend(T)	8-1-2016
461-120-0330	7-1-2016	Amend	8-1-2016
461-120-0340	4-1-2016	Amend	5-1-2016
461-120-0345	7-1-2016	Amend(T)	8-1-2016
461-120-0350	7-1-2016	Amend(T)	8-1-2016
461-120-0510	7-1-2016	Amend(T)	8-1-2016
461-125-0010	4-1-2016	Repeal	5-1-2016
461-125-0030	4-1-2016	Repeal	5-1-2016
461-125-0050	4-1-2016	Repeal	5-1-2016
461-125-0060	4-1-2016	Repeal	5-1-2016
461-125-0090	4-1-2016	Repeal	5-1-2016
461-125-0110	4-1-2016	Repeal	5-1-2016
461-125-0120	4-1-2016	Repeal	5-1-2016
461-125-0130	4-1-2016	Repeal	5-1-2016
461-125-0170	4-1-2016	Repeal	5-1-2016
461-125-0230	4-1-2016	Repeal	5-1-2016
461-125-0250	4-1-2016	Repeal	5-1-2016
461-125-0255	4-1-2016	Repeal	5-1-2016
461-125-0370	3-1-2016	Amend(T)	4-1-2016
461-125-0370	4-1-2016	Amend	5-1-2016
461-125-0370	5-10-2016	Amend	6-1-2016
461-125-0370	5-13-2016	Amend(T)	6-1-2016
461-125-0370	7-1-2016	Amend	8-1-2016
461-125-0370(T)	3-1-2016	Suspend	4-1-2016
461-125-0370(T)	4-1-2016	Repeal	5-1-2016
461-125-0370(T)	7-1-2016	Repeal	8-1-2016
461-125-0510	7-1-2016	Suspend	8-1-2016
461-125-0810	7-1-2016	Amend(T)	8-1-2016
461-125-0830(T)	1-1-2016	Repeal	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
461-130-0310	1-1-2016	Amend	2-1-2016
461-130-0310	1-1-2016	Amend(T)	2-1-2016
461-130-0310	4-1-2016	Amend	5-1-2016
461-130-0310(T)	4-1-2016	Repeal	5-1-2016
461-130-0315	4-1-2016	Amend	5-1-2016
461-130-0327	4-1-2016	Amend	5-1-2016
461-130-0327	7-1-2016	Amend	8-1-2016
461-130-0330	1-1-2016	Amend	2-1-2016
461-130-0330	4-1-2016	Amend	5-1-2016
461-130-0330	7-1-2016	Amend	8-1-2016
461-130-0335	4-1-2016	Amend	5-1-2016
461-130-0335	7-1-2016	Amend	8-1-2016
461-135-0070	4-1-2016	Amend	5-1-2016
461-135-0071	4-1-2016	Adopt	5-1-2016
461-135-0073	4-1-2016	Adopt	5-1-2016
461-135-0075	4-1-2016	Amend	5-1-2016
461-135-0087	4-1-2016	Repeal	5-1-2016
461-135-0089	7-1-2016	Amend	8-1-2016
461-135-0400	1-1-2016	Amend	2-1-2016
461-135-0400	7-1-2016	Amend	8-1-2016
461-135-0405	1-1-2016	Amend	2-1-2016
461-135-0405(T)	1-1-2016	Repeal	2-1-2016
461-135-0407	1-1-2016	Amend	2-1-2016
461-135-0407(T)	1-1-2016	Repeal	2-1-2016
461-135-0475	4-1-2016	Amend	5-1-2016
461-135-0485	4-1-2016	Amend	5-1-2016
461-135-0506	1-1-2016	Amend(T)	2-1-2016
461-135-0506	4-1-2016	Amend	5-1-2016
461-135-0506(T)	4-1-2016	Repeal	5-1-2016
461-135-0520	1-1-2016	Amend	2-1-2016
461-135-0520	2-5-2016	Amend(T)	3-1-2016
461-135-0520	3-2-2016	Amend(T)	4-1-2016
461-135-0520	4-1-2016	Amend	5-1-2016
461-135-0520	4-5-2016	Amend(T)	5-1-2016
461-135-0520	5-1-2016	Amend(T)	6-1-2016
461-135-0520(T)	3-2-2016	Suspend	4-1-2016
461-135-0520(T)	4-1-2016	Repeal	5-1-2016
461-135-0521	4-1-2016	Amend(T)	5-1-2016
461-135-0521	7-1-2016	Amend	8-1-2016
461-135-0521(T)	7-1-2016	Repeal	8-1-2016
461-135-0560	7-1-2016	Amend(T)	8-1-2016
461-135-0700	7-1-2016	Amend(T)	8-1-2016
461-135-0701	7-1-2016	Amend(T)	8-1-2016
461-135-0705	7-1-2016	Suspend	8-1-2016
461-135-0708	7-1-2016	Amend(T)	8-1-2016
461-135-0750	12-15-2015	Amend(T)	1-1-2016
461-135-0750	4-1-2016	Amend	5-1-2016
461-135-0750(T)	4-1-2016	Repeal	5-1-2016
461-135-0780	2-3-2016	Amend	3-1-2016
461-135-0835	7-1-2016	Amend	8-1-2016
461-135-0950	7-1-2016	Amend(T)	8-1-2016
461-135-0990	7-1-2016	Amend(T)	8-1-2016
461-135-1250	4-1-2016	Amend	5-1-2016
461-135-1270	4-1-2016	Adopt	5-1-2016
461-140-0010	7-1-2016	Amend(T)	8-1-2016
461-140-0020	1-1-2016	Amend	2-1-2016
461-140-0040	7-1-2016	Amend(T)	8-1-2016
461-140-0120	1-1-2016	Amend	2-1-2016
461-140-0120	7-1-2016	Amend(T)	8-1-2016
461-140-0210	7-1-2016	Amend(T)	8-1-2016
461-140-0242	7-1-2016	Amend(T)	8-1-2016
461-140-0250	1-1-2016	Amend	2-1-2016
461-140-0250	7-1-2016	Amend(T)	8-1-2016
461-140-0296	7-1-2016	Amend(T)	8-1-2016
461-140-0300	7-1-2016	Amend(T)	8-1-2016
461-145-0000	7-1-2016	Adopt(T)	8-1-2016
461-145-0005	7-1-2016	Amend(T)	8-1-2016
461-145-0010	1-1-2016	Amend	2-1-2016
461-145-0020	1-1-2016	Amend	2-1-2016
461-145-0040	1-1-2016	Amend	2-1-2016
461-145-0040	7-1-2016	Amend(T)	8-1-2016
461-145-0050	1-1-2016	Amend	2-1-2016
461-145-0050	7-1-2016	Amend(T)	8-1-2016
461-145-0080	1-1-2016	Amend	2-1-2016
461-145-0089	1-1-2016	Amend	2-1-2016
461-145-0110	7-1-2016	Amend(T)	8-1-2016
461-145-0220	1-1-2016	Amend	2-1-2016
461-145-0220	7-1-2016	Amend(T)	8-1-2016
461-145-0230	7-1-2016	Amend(T)	8-1-2016
461-145-0240	1-1-2016	Amend	2-1-2016
461-145-0240	7-1-2016	Amend(T)	8-1-2016
461-145-0250	7-1-2016	Amend(T)	8-1-2016
461-145-0252	1-1-2016	Amend	2-1-2016
461-145-0259	1-1-2016	Adopt	2-1-2016
461-145-0259	7-1-2016	Amend(T)	8-1-2016
461-145-0260	1-1-2016	Amend	2-1-2016
461-145-0260	7-1-2016	Amend(T)	8-1-2016
461-145-0280	1-1-2016	Amend	2-1-2016
461-145-0300	1-1-2016	Amend	2-1-2016
461-145-0310	1-1-2016	Amend	2-1-2016
461-145-0320	1-1-2016	Amend	2-1-2016
461-145-0320	7-1-2016	Amend(T)	8-1-2016
461-145-0330	1-1-2016	Amend	2-1-2016
461-145-0330	7-1-2016	Amend(T)	8-1-2016
461-145-0340	7-1-2016	Amend(T)	8-1-2016
461-145-0360	1-1-2016	Amend	2-1-2016
461-145-0360	7-1-2016	Amend	8-1-2016
461-145-0360	7-1-2016	Amend(T)	8-1-2016
461-145-0365	1-1-2016	Amend	2-1-2016
461-145-0365	7-1-2016	Amend(T)	8-1-2016
461-145-0370	7-1-2016	Amend(T)	8-1-2016
461-145-0380	1-1-2016	Amend	2-1-2016
461-145-0380	7-1-2016	Amend	8-1-2016
461-145-0410	1-1-2016	Amend	2-1-2016
461-145-0410	4-1-2016	Amend	5-1-2016
461-145-0410	7-1-2016	Amend(T)	8-1-2016
461-145-0420	1-1-2016	Amend	2-1-2016
461-145-0420	7-1-2016	Amend(T)	8-1-2016
461-145-0430	1-1-2016	Amend	2-1-2016
461-145-0455	7-1-2016	Amend(T)	8-1-2016
461-145-0460	1-1-2016	Amend	2-1-2016
461-145-0460	7-1-2016	Amend(T)	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
461-145-0470	7-1-2016	Amend(T)	8-1-2016
461-145-0490	1-1-2016	Amend	2-1-2016
461-145-0510	1-1-2016	Amend	2-1-2016
461-145-0510	7-1-2016	Amend(T)	8-1-2016
461-145-0540	1-1-2016	Amend	2-1-2016
461-145-0540	7-1-2016	Amend(T)	8-1-2016
461-145-0600	1-1-2016	Amend	2-1-2016
461-145-0600	7-1-2016	Amend(T)	8-1-2016
461-145-0910	1-1-2016	Amend	2-1-2016
461-145-0910	7-1-2016	Amend(T)	8-1-2016
461-145-0910(T)	1-1-2016	Repeal	2-1-2016
461-145-0920	7-1-2016	Amend(T)	8-1-2016
461-145-0930	7-1-2016	Amend(T)	8-1-2016
461-150-0050	1-1-2016	Amend	2-1-2016
461-150-0050	7-1-2016	Amend(T)	8-1-2016
461-150-0090	1-1-2016	Amend	2-1-2016
461-155-0010	7-1-2016	Amend(T)	8-1-2016
461-155-0020	4-1-2016	Amend	5-1-2016
461-155-0020	7-1-2016	Amend(T)	8-1-2016
461-155-0030	1-1-2016	Amend	2-1-2016
461-155-0030	4-1-2016	Amend	5-1-2016
461-155-0030	5-12-2016	Amend(T)	6-1-2016
461-155-0035	1-1-2016	Amend	2-1-2016
461-155-0150	1-1-2016	Amend(T)	2-1-2016
461-155-0150	3-1-2016	Amend(T)	4-1-2016
461-155-0150	4-1-2016	Amend	5-1-2016
461-155-0150	7-1-2016	Amend	8-1-2016
461-155-0150(T)	3-1-2016	Suspend	4-1-2016
461-155-0150(T)	4-1-2016	Repeal	5-1-2016
461-155-0180	4-1-2016	Amend	5-1-2016
461-155-0210	7-1-2016	Amend(T)	8-1-2016
461-155-0290	3-1-2016	Amend	4-1-2016
461-155-0291	3-1-2016	Amend	4-1-2016
461-155-0295	3-1-2016	Amend	4-1-2016
461-155-0360	7-1-2016	Amend(T)	8-1-2016
461-155-0575	1-1-2016	Amend	2-1-2016
461-155-0580	7-1-2016	Amend(T)	8-1-2016
461-155-0600	7-1-2016	Amend(T)	8-1-2016
461-155-0610	7-1-2016	Amend(T)	8-1-2016
461-155-0620	7-1-2016	Amend(T)	8-1-2016
461-155-0640	7-1-2016	Amend(T)	8-1-2016
461-155-0670	7-1-2016	Amend(T)	8-1-2016
461-160-0010	1-1-2016	Amend	2-1-2016
461-160-0010	7-1-2016	Amend	8-1-2016
461-160-0010	7-1-2016	Amend(T)	8-1-2016
461-160-0015	1-1-2016	Amend	2-1-2016
461-160-0015	7-1-2016	Amend	8-1-2016
461-160-0015	7-1-2016	Amend(T)	8-1-2016
461-160-0040	1-1-2016	Amend	2-1-2016
461-160-0040(T)	1-1-2016	Repeal	2-1-2016
461-160-0055	7-1-2016	Amend(T)	8-1-2016
461-160-0060	7-1-2016	Amend(T)	8-1-2016
461-160-0100	4-1-2016	Amend	5-1-2016
461-160-0300	1-1-2016	Amend	2-1-2016
461-160-0300(T)	1-1-2016	Repeal	2-1-2016
461-160-0410	4-1-2016	Amend(T)	5-1-2016
461-160-0410	7-1-2016	Amend	8-1-2016
461-160-0410(T)	7-1-2016	Repeal	8-1-2016
461-160-0500	7-1-2016	Amend(T)	8-1-2016
461-160-0550	1-1-2016	Amend	2-1-2016
461-160-0551	1-1-2016	Amend	2-1-2016
461-160-0552	1-1-2016	Amend	2-1-2016
461-160-0620	7-1-2016	Amend	8-1-2016
461-160-0620	7-1-2016	Amend(T)	8-1-2016
461-165-0010	7-1-2016	Amend	8-1-2016
461-165-0030	1-1-2016	Amend	2-1-2016
461-165-0030	4-1-2016	Amend	5-1-2016
461-165-0030	7-1-2016	Amend(T)	8-1-2016
461-165-0050	7-1-2016	Amend(T)	8-1-2016
461-165-0120	7-1-2016	Amend(T)	8-1-2016
461-165-0180	1-20-2016	Amend(T)	3-1-2016
461-165-0180	3-14-2016	Amend(T)	4-1-2016
461-165-0180	5-23-2016	Amend(T)	7-1-2016
461-165-0180	7-1-2016	Amend	8-1-2016
461-165-0180	7-1-2016	Amend(T)	8-1-2016
461-165-0180(T)	3-14-2016	Suspend	4-1-2016
461-165-0180(T)	5-23-2016	Suspend	7-1-2016
461-165-0180(T)	7-1-2016	Repeal	8-1-2016
461-170-0011	1-1-2016	Amend	2-1-2016
461-170-0011	4-1-2016	Amend	5-1-2016
461-170-0011	7-1-2016	Amend(T)	8-1-2016
461-170-0101	1-1-2016	Amend	2-1-2016
461-170-0103	1-1-2016	Amend	2-1-2016
461-170-0103(T)	1-1-2016	Repeal	2-1-2016
461-170-0150	1-1-2016	Amend	2-1-2016
461-170-0150(T)	1-1-2016	Repeal	2-1-2016
461-170-0160	1-1-2016	Amend	2-1-2016
461-170-0160(T)	1-1-2016	Repeal	2-1-2016
461-175-0200	1-1-2016	Amend	2-1-2016
461-175-0200	4-1-2016	Amend	5-1-2016
461-175-0200	7-1-2016	Amend	8-1-2016
461-175-0200(T)	1-1-2016	Repeal	2-1-2016
461-175-0210	4-1-2016	Amend	5-1-2016
461-175-0210	7-1-2016	Amend(T)	8-1-2016
461-175-0220	1-1-2016	Amend	2-1-2016
461-175-0220	7-1-2016	Amend	8-1-2016
461-175-0222	1-1-2016	Amend	2-1-2016
461-175-0222(T)	1-1-2016	Repeal	2-1-2016
461-175-0240	7-1-2016	Amend(T)	8-1-2016
461-175-0250	1-1-2016	Amend	2-1-2016
461-175-0300	1-1-2016	Amend	2-1-2016
461-175-0300	4-1-2016	Amend	5-1-2016
461-175-0300(T)	1-1-2016	Repeal	2-1-2016
461-175-0305	1-1-2016	Amend	2-1-2016
461-175-0310	1-1-2016	Amend	2-1-2016
461-175-0310	7-1-2016	Amend(T)	8-1-2016
461-175-0340	1-1-2016	Amend	2-1-2016
461-180-0010	12-15-2015	Amend(T)	1-1-2016
461-180-0010	1-22-2016	Amend(T)	3-1-2016
461-180-0010	4-1-2016	Amend	5-1-2016
461-180-0010	7-1-2016	Amend(T)	8-1-2016
461-180-0010(T)	1-22-2016	Suspend	3-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
461-180-0010(T)	4-1-2016	Repeal	5-1-2016
461-180-0050	4-1-2016	Amend	5-1-2016
461-180-0065	7-1-2016	Amend(T)	8-1-2016
461-180-0070	7-1-2016	Amend(T)	8-1-2016
461-180-0090	12-15-2015	Amend(T)	1-1-2016
461-180-0090	1-22-2016	Amend(T)	3-1-2016
461-180-0090	4-1-2016	Amend	5-1-2016
461-180-0090	7-1-2016	Amend(T)	8-1-2016
461-180-0090(T)	1-22-2016	Suspend	3-1-2016
461-180-0090(T)	4-1-2016	Repeal	5-1-2016
461-180-0135	4-1-2016	Adopt(T)	5-1-2016
461-180-0135	7-1-2016	Adopt	8-1-2016
461-180-0135(T)	7-1-2016	Repeal	8-1-2016
461-180-0140	12-15-2015	Amend(T)	1-1-2016
461-180-0140	1-22-2016	Amend(T)	3-1-2016
461-180-0140	4-1-2016	Amend	5-1-2016
461-180-0140(T)	1-22-2016	Suspend	3-1-2016
461-180-0140(T)	4-1-2016	Repeal	5-1-2016
461-190-0211	12-28-2015	Amend	2-1-2016
461-190-0211	7-1-2016	Amend	8-1-2016
461-190-0231	7-1-2016	Amend	8-1-2016
461-190-0310	4-1-2016	Amend	5-1-2016
461-190-0360	11-30-2015	Amend(T)	1-1-2016
461-190-0360	4-1-2016	Amend	5-1-2016
461-190-0360(T)	4-1-2016	Repeal	5-1-2016
461-190-0406	4-1-2016	Amend	5-1-2016
461-190-0500	2-5-2016	Adopt(T)	3-1-2016
461-190-0500	4-1-2016	Adopt	5-1-2016
461-190-0500(T)	4-1-2016	Repeal	5-1-2016
461-193-0010	7-1-2016	Repeal	8-1-2016
461-193-0320	7-1-2016	Amend	8-1-2016
461-193-0890	7-1-2016	Repeal	8-1-2016
461-193-0940	7-1-2016	Repeal	8-1-2016
461-193-0960	7-1-2016	Repeal	8-1-2016
461-193-1230	7-1-2016	Repeal	8-1-2016
461-195-0501	7-1-2016	Amend	8-1-2016
461-195-0521	1-1-2016	Amend	2-1-2016
461-195-0521	7-1-2016	Amend(T)	8-1-2016
461-195-0541	7-1-2016	Amend(T)	8-1-2016
461-195-0621	1-1-2016	Amend	2-1-2016
462-160-0130	6-17-2016	Amend	8-1-2016
462-200-0660	6-6-2016	Adopt	7-1-2016
462-200-0670	6-6-2016	Adopt	7-1-2016
462-220-0040	5-9-2016	Amend	6-1-2016
462-220-0080	1-27-2016	Amend	3-1-2016
471-010-0080	1-29-2016	Amend(T)	3-1-2016
471-030-0017	7-1-2016	Amend	8-1-2016
543-001-0010	1-11-2016	Amend(T)	2-1-2016
543-001-0010	6-13-2016	Amend	7-1-2016
543-010-0003	1-11-2016	Amend(T)	2-1-2016
543-010-0003	6-13-2016	Amend	7-1-2016
543-010-0016	1-11-2016	Amend(T)	2-1-2016
543-010-0016	6-13-2016	Amend	7-1-2016
543-010-0021	1-11-2016	Amend(T)	2-1-2016
543-010-0021	6-13-2016	Amend	7-1-2016
543-010-0022	1-11-2016	Suspend	2-1-2016
543-010-0022	6-13-2016	Repeal	7-1-2016
543-010-0026	1-11-2016	Adopt(T)	2-1-2016
543-010-0026	6-13-2016	Adopt	7-1-2016
543-010-0030	1-11-2016	Amend(T)	2-1-2016
543-010-0030	6-13-2016	Amend	7-1-2016
543-010-0032	1-11-2016	Suspend	2-1-2016
543-010-0032	6-13-2016	Repeal	7-1-2016
543-020-0010	1-11-2016	Suspend	2-1-2016
543-020-0010	6-13-2016	Repeal	7-1-2016
543-020-0025	1-11-2016	Suspend	2-1-2016
543-020-0025	6-13-2016	Repeal	7-1-2016
543-020-0026	1-11-2016	Suspend	2-1-2016
543-020-0026	6-13-2016	Repeal	7-1-2016
543-020-0030	1-11-2016	Suspend	2-1-2016
543-020-0030	6-13-2016	Repeal	7-1-2016
543-020-0050	1-11-2016	Adopt(T)	2-1-2016
543-020-0050	6-13-2016	Adopt	7-1-2016
543-020-0055	1-11-2016	Adopt(T)	2-1-2016
543-020-0055	6-13-2016	Adopt	7-1-2016
543-020-0060	1-11-2016	Adopt(T)	2-1-2016
543-020-0060	6-13-2016	Adopt	7-1-2016
543-020-0070	1-11-2016	Adopt(T)	2-1-2016
543-020-0070	6-13-2016	Adopt	7-1-2016
543-020-0080	1-11-2016	Adopt(T)	2-1-2016
543-020-0080	6-13-2016	Adopt	7-1-2016
543-060-0020	1-11-2016	Amend(T)	2-1-2016
543-060-0020	6-13-2016	Amend	7-1-2016
543-060-0030	1-11-2016	Amend(T)	2-1-2016
543-060-0030	6-13-2016	Amend	7-1-2016
543-060-0040	1-11-2016	Amend(T)	2-1-2016
543-060-0040	6-13-2016	Amend	7-1-2016
543-060-0070	1-11-2016	Amend(T)	2-1-2016
543-060-0070	6-13-2016	Amend	7-1-2016
573-040-0005	5-4-2016	Amend	6-1-2016
573-050-0010	5-4-2016	Amend	6-1-2016
573-050-0025	5-4-2016	Amend	6-1-2016
573-050-0030	5-4-2016	Amend	6-1-2016
573-050-0035	5-4-2016	Amend	6-1-2016
573-050-0045	5-4-2016	Amend	6-1-2016
575-001-0000	12-18-2015	Amend	2-1-2016
575-001-0005	12-18-2015	Amend	2-1-2016
575-001-0010	12-18-2015	Amend	2-1-2016
575-001-0015	12-18-2015	Amend	2-1-2016
575-001-0030	12-18-2015	Amend	2-1-2016
575-001-0035	12-18-2015	Amend	2-1-2016
575-007-0210	12-18-2015	Amend	2-1-2016
575-007-0240	12-18-2015	Amend	2-1-2016
575-007-0280	12-18-2015	Amend	2-1-2016
575-007-0310	12-18-2015	Amend	2-1-2016
575-007-0330	12-18-2015	Amend	2-1-2016
575-007-0340	12-18-2015	Amend	2-1-2016
575-007-0380	12-18-2015	Amend	2-1-2016
575-030-0005	12-18-2015	Amend	2-1-2016
575-030-0005	4-21-2016	Amend	6-1-2016
575-031-0005	12-18-2015	Amend	2-1-2016
575-031-0005	4-21-2016	Amend	6-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
575-031-0010	12-18-2015	Amend	2-1-2016
575-031-0010	4-21-2016	Amend	6-1-2016
575-031-0015	4-21-2016	Amend	6-1-2016
575-031-0016	4-21-2016	Amend	6-1-2016
575-031-0020	12-18-2015	Amend	2-1-2016
575-031-0022	12-18-2015	Amend	2-1-2016
575-031-0022	4-21-2016	Amend	6-1-2016
575-031-0023	12-18-2015	Amend	2-1-2016
575-031-0023	4-21-2016	Amend	6-1-2016
575-031-0025	12-18-2015	Amend	2-1-2016
575-031-0025	4-21-2016	Amend	6-1-2016
575-031-0030	4-21-2016	Amend	6-1-2016
575-031-0045	12-18-2015	Amend	2-1-2016
575-031-0045	4-21-2016	Amend	6-1-2016
575-031-0046	4-21-2016	Amend	6-1-2016
575-031-0060	4-21-2016	Adopt	6-1-2016
575-035-0005	12-18-2015	Amend	2-1-2016
575-035-0010	12-18-2015	Amend	2-1-2016
575-035-0015	12-18-2015	Amend	2-1-2016
575-035-0020	12-18-2015	Amend	2-1-2016
575-035-0025	12-18-2015	Amend	2-1-2016
575-035-0030	12-18-2015	Amend	2-1-2016
575-035-0040	12-18-2015	Amend	2-1-2016
575-035-0045	12-18-2015	Amend	2-1-2016
575-035-0046	12-18-2015	Amend	2-1-2016
575-035-0050	12-18-2015	Amend	2-1-2016
575-035-0051	12-18-2015	Amend	2-1-2016
575-035-0055	12-18-2015	Amend	2-1-2016
575-037-0005	12-18-2015	Amend	2-1-2016
575-037-0010	12-18-2015	Amend	2-1-2016
575-037-0020	12-18-2015	Amend	2-1-2016
575-037-0030	12-18-2015	Amend	2-1-2016
575-037-0040	12-18-2015	Amend	2-1-2016
575-038-0000	12-18-2015	Amend	2-1-2016
575-038-0010	12-18-2015	Amend	2-1-2016
575-038-0020	12-18-2015	Amend	2-1-2016
575-038-0030	12-18-2015	Amend	2-1-2016
575-038-0040	12-18-2015	Amend	2-1-2016
575-039-0010	4-21-2016	Adopt	6-1-2016
575-039-0020	4-21-2016	Adopt	6-1-2016
575-039-0030	4-21-2016	Adopt	6-1-2016
575-039-0040	4-21-2016	Adopt	6-1-2016
575-039-0050	4-21-2016	Adopt	6-1-2016
575-039-0060	4-21-2016	Adopt	6-1-2016
575-039-0070	4-21-2016	Adopt	6-1-2016
575-039-0080	4-21-2016	Adopt	6-1-2016
575-039-0090	4-21-2016	Adopt	6-1-2016
575-039-0100	4-21-2016	Adopt	6-1-2016
575-039-0110	4-21-2016	Adopt	6-1-2016
575-039-0120	4-21-2016	Adopt	6-1-2016
575-039-0140	4-21-2016	Adopt	6-1-2016
575-039-0150	4-21-2016	Adopt	6-1-2016
575-045-0005	12-18-2015	Amend	2-1-2016
575-050-0005	12-18-2015	Amend	2-1-2016
575-050-0010	12-18-2015	Amend	2-1-2016
575-050-0015	12-18-2015	Amend	2-1-2016
575-050-0020	12-18-2015	Amend	2-1-2016
575-050-0025	12-18-2015	Amend	2-1-2016
575-050-0030	12-18-2015	Amend	2-1-2016
575-050-0035	12-18-2015	Amend	2-1-2016
575-050-0040	12-18-2015	Amend	2-1-2016
575-050-0042	12-18-2015	Amend	2-1-2016
575-050-0045	12-18-2015	Amend	2-1-2016
575-050-0050	12-18-2015	Amend	2-1-2016
575-060-0005	12-18-2015	Amend	2-1-2016
575-060-0020	12-18-2015	Amend	2-1-2016
575-063-0010	12-18-2015	Amend	2-1-2016
575-065-0001	12-18-2015	Amend	2-1-2016
575-065-0045	12-18-2015	Amend	2-1-2016
575-065-0055	12-18-2015	Amend	2-1-2016
575-070-0005	12-18-2015	Amend	2-1-2016
575-070-0010	12-18-2015	Amend	2-1-2016
575-070-0020	12-18-2015	Amend	2-1-2016
575-070-0030	12-18-2015	Amend	2-1-2016
575-070-0040	12-18-2015	Amend	2-1-2016
575-070-0045	12-18-2015	Amend	2-1-2016
575-070-0050	12-18-2015	Amend	2-1-2016
575-070-0060	12-18-2015	Amend	2-1-2016
575-070-0070	12-18-2015	Amend	2-1-2016
575-070-0080	12-18-2015	Amend	2-1-2016
575-070-0090	12-18-2015	Amend	2-1-2016
575-071-0000	12-18-2015	Amend	2-1-2016
575-071-0040	12-18-2015	Amend	2-1-2016
575-072-0000	12-18-2015	Amend	2-1-2016
575-072-0010	12-18-2015	Amend	2-1-2016
575-072-0040	12-18-2015	Amend	2-1-2016
575-072-0050	12-18-2015	Amend	2-1-2016
575-072-0060	12-18-2015	Amend	2-1-2016
575-072-0080	12-18-2015	Amend	2-1-2016
575-072-0090	12-18-2015	Amend	2-1-2016
575-073-0000	12-18-2015	Amend	2-1-2016
575-074-0000	12-18-2015	Amend	2-1-2016
575-075-0001	12-18-2015	Amend	2-1-2016
575-075-0005	12-18-2015	Amend	2-1-2016
575-075-0007	12-18-2015	Amend	2-1-2016
575-075-0008	12-18-2015	Amend	2-1-2016
575-075-0010	12-18-2015	Amend	2-1-2016
575-075-0030	12-18-2015	Amend	2-1-2016
575-075-0040	12-18-2015	Amend	2-1-2016
575-075-0043	12-18-2015	Amend	2-1-2016
575-075-0044	12-18-2015	Amend	2-1-2016
575-075-0045	12-18-2015	Amend	2-1-2016
575-075-0046	12-18-2015	Amend	2-1-2016
575-075-0047	12-18-2015	Amend	2-1-2016
575-075-0049	12-18-2015	Amend	2-1-2016
575-075-0050	12-18-2015	Amend	2-1-2016
575-075-0055	12-18-2015	Amend	2-1-2016
575-076-0010	12-18-2015	Amend	2-1-2016
575-080-0100	12-18-2015	Amend	2-1-2016
575-085-0000	12-18-2015	Amend	2-1-2016
575-085-0020	12-18-2015	Amend	2-1-2016
575-085-0030	12-18-2015	Amend	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
575-085-0040	12-18-2015	Amend	2-1-2016
575-085-0050	12-18-2015	Amend	2-1-2016
575-085-0060	12-18-2015	Amend	2-1-2016
575-085-0070	12-18-2015	Amend	2-1-2016
575-090-0020	12-18-2015	Amend	2-1-2016
575-090-0030	12-18-2015	Amend	2-1-2016
575-090-0040	12-18-2015	Amend	2-1-2016
575-090-0050	12-18-2015	Amend	2-1-2016
575-095-0005	12-18-2015	Amend	2-1-2016
581-001-0002	4-7-2016	Amend	5-1-2016
581-005-0001	4-7-2016	Repeal	5-1-2016
581-015-2200	12-21-2015	Amend	2-1-2016
581-015-2595	12-18-2015	Amend	2-1-2016
581-015-2930	12-22-2015	Amend	2-1-2016
581-017-0010	5-17-2016	Amend	7-1-2016
581-017-0020	5-17-2016	Amend	7-1-2016
581-017-0215	5-17-2016	Amend	7-1-2016
581-017-0287	12-18-2015	Adopt	2-1-2016
581-017-0291	12-18-2015	Adopt	2-1-2016
581-017-0294	12-18-2015	Adopt	2-1-2016
581-017-0297	12-18-2015	Adopt	2-1-2016
581-017-0301	12-28-2015	Amend(T)	2-1-2016
581-017-0301	5-17-2016	Amend	7-1-2016
581-017-0309	12-28-2015	Amend(T)	2-1-2016
581-017-0312	5-17-2016	Amend	7-1-2016
581-017-0318	12-28-2015	Amend(T)	2-1-2016
581-017-0318	5-17-2016	Amend	7-1-2016
581-017-0321	12-28-2015	Amend(T)	2-1-2016
581-017-0321	3-22-2016	Amend	5-1-2016
581-017-0324	12-28-2015	Amend(T)	2-1-2016
581-017-0324	3-22-2016	Amend	5-1-2016
581-017-0327	12-28-2015	Amend(T)	2-1-2016
581-017-0327	3-22-2016	Amend	5-1-2016
581-017-0330	12-28-2015	Amend(T)	2-1-2016
581-017-0330	3-22-2016	Amend	5-1-2016
581-017-0333	12-28-2015	Amend(T)	2-1-2016
581-017-0333	3-22-2016	Amend	5-1-2016
581-017-0335	5-17-2016	Amend	7-1-2016
581-017-0347	5-17-2016	Amend	7-1-2016
581-017-0350	2-5-2016	Amend	3-1-2016
581-017-0353	2-5-2016	Amend	3-1-2016
581-017-0356	2-5-2016	Amend	3-1-2016
581-017-0359	2-5-2016	Amend	3-1-2016
581-017-0362	2-5-2016	Amend	3-1-2016
581-017-0365	4-7-2016	Adopt	5-1-2016
581-017-0367	4-7-2016	Adopt	5-1-2016
581-017-0369	4-7-2016	Adopt	5-1-2016
581-017-0371	4-7-2016	Adopt	5-1-2016
581-017-0373	4-7-2016	Adopt	5-1-2016
581-017-0375	4-7-2016	Adopt	5-1-2016
581-017-0380	2-5-2016	Adopt	3-1-2016
581-017-0383	2-5-2016	Adopt	3-1-2016
581-017-0386	2-5-2016	Adopt	3-1-2016
581-017-0389	2-5-2016	Adopt	3-1-2016
581-017-0392	2-5-2016	Adopt	3-1-2016
581-017-0395	2-5-2016	Adopt	3-1-2016
581-017-0432	2-5-2016	Adopt	3-1-2016
581-017-0435	2-5-2016	Adopt	3-1-2016
581-017-0438	2-5-2016	Adopt	3-1-2016
581-017-0441	2-5-2016	Adopt	3-1-2016
581-017-0444	2-5-2016	Adopt	3-1-2016
581-017-0447	2-5-2016	Adopt	3-1-2016
581-017-0450	2-5-2016	Adopt	3-1-2016
581-017-0453	2-5-2016	Adopt	3-1-2016
581-017-0456	2-5-2016	Adopt	3-1-2016
581-017-0459	2-5-2016	Adopt	3-1-2016
581-017-0462	2-5-2016	Adopt	3-1-2016
581-017-0465	12-28-2015	Adopt(T)	2-1-2016
581-017-0466	3-22-2016	Adopt	5-1-2016
581-017-0469	12-28-2015	Adopt(T)	2-1-2016
581-017-0470	3-22-2016	Adopt	5-1-2016
581-017-0473	12-28-2015	Adopt(T)	2-1-2016
581-017-0474	3-22-2016	Adopt	5-1-2016
581-017-0477	12-28-2015	Adopt(T)	2-1-2016
581-017-0478	3-22-2016	Adopt	5-1-2016
581-017-0481	12-28-2015	Adopt(T)	2-1-2016
581-017-0482	3-22-2016	Adopt	5-1-2016
581-017-0485	12-28-2015	Adopt(T)	2-1-2016
581-017-0486	3-22-2016	Adopt	5-1-2016
581-017-0550	6-15-2016	Adopt	7-1-2016
581-017-0553	6-15-2016	Adopt	7-1-2016
581-017-0556	6-15-2016	Adopt	7-1-2016
581-017-0559	6-15-2016	Adopt	7-1-2016
581-017-0562	6-15-2016	Adopt	7-1-2016
581-017-0565	6-15-2016	Adopt	7-1-2016
581-018-0010	5-17-2016	Amend	7-1-2016
581-018-0020	5-17-2016	Amend	7-1-2016
581-018-0110	2-5-2016	Amend	3-1-2016
581-018-0110	5-17-2016	Amend	7-1-2016
581-018-0120	2-5-2016	Amend	3-1-2016
581-018-0125	5-17-2016	Amend	7-1-2016
581-018-0130	12-18-2015	Amend	2-1-2016
581-018-0145	12-18-2015	Amend	2-1-2016
581-018-0148	12-18-2015	Amend	2-1-2016
581-018-0215	5-17-2016	Amend	7-1-2016
581-018-0265	5-17-2016	Amend	7-1-2016
581-018-0325	5-17-2016	Amend	7-1-2016
581-018-0336	5-17-2016	Amend	7-1-2016
581-018-0509	5-17-2016	Amend	7-1-2016
581-018-0529	5-17-2016	Amend	7-1-2016
581-018-0575	5-17-2016	Amend	7-1-2016
581-018-0584	5-17-2016	Amend	7-1-2016
581-018-0590	5-17-2016	Amend	7-1-2016
581-019-0036	5-3-2016	Adopt	6-1-2016
581-019-0037	5-3-2016	Adopt	6-1-2016
581-019-0038	5-3-2016	Adopt	6-1-2016
581-019-0039	5-3-2016	Adopt	6-1-2016
581-019-0040	5-3-2016	Adopt	6-1-2016
581-019-0041	5-3-2016	Adopt	6-1-2016
581-019-0042	5-3-2016	Adopt	6-1-2016
581-019-0043	5-3-2016	Adopt	6-1-2016
581-019-0044	5-3-2016	Adopt	6-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
581-019-0045	5-3-2016	Adopt	6-1-2016
581-019-0046	5-3-2016	Adopt	6-1-2016
581-019-0047	5-3-2016	Adopt	6-1-2016
581-019-0048	5-3-2016	Adopt	6-1-2016
581-019-0049	5-3-2016	Adopt	6-1-2016
581-020-0530	12-28-2015	Adopt(T)	2-1-2016
581-020-0531	3-22-2016	Adopt	5-1-2016
581-020-0533	12-28-2015	Adopt(T)	2-1-2016
581-020-0534	3-22-2016	Adopt	5-1-2016
581-020-0536	12-28-2015	Adopt(T)	2-1-2016
581-020-0537	3-22-2016	Adopt	5-1-2016
581-020-0539	12-28-2015	Adopt(T)	2-1-2016
581-020-0540	3-22-2016	Adopt	5-1-2016
581-020-0541	12-28-2015	Adopt(T)	2-1-2016
581-020-0542	3-22-2016	Adopt	5-1-2016
581-020-0600	2-5-2016	Adopt	3-1-2016
581-020-0603	2-5-2016	Adopt	3-1-2016
581-020-0606	2-5-2016	Adopt	3-1-2016
581-020-0609	2-5-2016	Adopt	3-1-2016
581-020-0612	2-5-2016	Adopt	3-1-2016
581-020-0615	2-5-2016	Adopt	3-1-2016
581-021-0017	6-15-2016	Adopt	7-1-2016
581-021-0037	3-22-2016	Amend	5-1-2016
581-021-0043	2-5-2016	Adopt	3-1-2016
581-021-0043	4-28-2016	Amend	6-1-2016
581-021-0047	3-22-2016	Amend	5-1-2016
581-021-0065	2-5-2016	Amend	3-1-2016
581-021-0070	2-5-2016	Amend	3-1-2016
581-021-0077	2-5-2016	Amend	3-1-2016
581-021-0505	4-7-2016	Adopt	5-1-2016
581-021-0580	4-28-2016	Adopt	6-1-2016
581-021-0582	4-28-2016	Adopt	6-1-2016
581-021-0584	4-28-2016	Adopt	6-1-2016
581-022-0102	12-18-2015	Amend	2-1-2016
581-022-0421	12-22-2015	Amend	2-1-2016
581-022-0610	12-21-2015	Amend	2-1-2016
581-022-0617	3-22-2016	Amend	5-1-2016
581-022-1133	4-28-2016	Amend	6-1-2016
581-022-1310	4-7-2016	Amend	5-1-2016
581-022-1420	12-22-2015	Amend	2-1-2016
581-022-1440	3-22-2016	Amend	5-1-2016
581-022-1723	5-5-2016	Amend	6-1-2016
581-022-1910	12-18-2015	Amend	2-1-2016
581-022-2130	5-17-2016	Amend	7-1-2016
581-023-0006	2-5-2016	Amend	3-1-2016
581-023-0040	2-5-2016	Amend	3-1-2016
581-023-0102	2-5-2016	Amend	3-1-2016
581-023-0106	3-22-2016	Amend	5-1-2016
581-023-0250	2-5-2016	Adopt	3-1-2016
581-024-0275	12-22-2015	Amend	2-1-2016
581-026-0210	12-18-2015	Amend	2-1-2016
581-027-0005	4-28-2016	Adopt	6-1-2016
581-027-0010	4-28-2016	Adopt	6-1-2016
581-027-0015	4-28-2016	Adopt	6-1-2016
581-027-0020	4-28-2016	Adopt	6-1-2016
581-027-0025	4-28-2016	Adopt	6-1-2016
581-044-0250	12-18-2015	Amend	2-1-2016
583-001-0000	2-19-2016	Amend	4-1-2016
583-001-0000(T)	2-19-2016	Repeal	4-1-2016
583-001-0005	2-19-2016	Amend	4-1-2016
583-001-0005(T)	2-19-2016	Repeal	4-1-2016
583-001-0015	2-19-2016	Amend	4-1-2016
583-001-0015(T)	2-19-2016	Repeal	4-1-2016
583-030-0005	2-19-2016	Amend	4-1-2016
583-030-0005(T)	2-19-2016	Repeal	4-1-2016
583-030-0009	2-19-2016	Amend	4-1-2016
583-030-0009(T)	2-19-2016	Repeal	4-1-2016
583-030-0010	2-19-2016	Amend	4-1-2016
583-030-0010(T)	2-19-2016	Repeal	4-1-2016
583-030-0011	2-19-2016	Repeal	4-1-2016
583-030-0015	2-19-2016	Amend	4-1-2016
583-030-0015(T)	2-19-2016	Repeal	4-1-2016
583-030-0016	2-19-2016	Amend	4-1-2016
583-030-0016(T)	2-19-2016	Repeal	4-1-2016
583-030-0020	2-19-2016	Amend	4-1-2016
583-030-0020(T)	2-19-2016	Repeal	4-1-2016
583-030-0025	2-19-2016	Amend	4-1-2016
583-030-0025(T)	2-19-2016	Repeal	4-1-2016
583-030-0030	2-19-2016	Amend	4-1-2016
583-030-0030(T)	2-19-2016	Repeal	4-1-2016
583-030-0032	2-19-2016	Amend	4-1-2016
583-030-0032(T)	2-19-2016	Repeal	4-1-2016
583-030-0035	2-19-2016	Amend	4-1-2016
583-030-0035(T)	2-19-2016	Repeal	4-1-2016
583-030-0036	2-19-2016	Amend	4-1-2016
583-030-0036(T)	2-19-2016	Repeal	4-1-2016
583-030-0041	2-19-2016	Amend	4-1-2016
583-030-0041(T)	2-19-2016	Repeal	4-1-2016
583-030-0042	2-19-2016	Amend	4-1-2016
583-030-0042(T)	2-19-2016	Repeal	4-1-2016
583-030-0043	2-19-2016	Amend	4-1-2016
583-030-0043(T)	2-19-2016	Repeal	4-1-2016
583-030-0045	2-19-2016	Amend	4-1-2016
583-030-0045(T)	2-19-2016	Repeal	4-1-2016
583-030-0046	2-19-2016	Amend	4-1-2016
583-030-0046(T)	2-19-2016	Repeal	4-1-2016
583-030-0049	2-19-2016	Amend	4-1-2016
583-030-0049(T)	2-19-2016	Repeal	4-1-2016
583-030-0051	2-19-2016	Adopt	4-1-2016
583-030-0051(T)	2-19-2016	Repeal	4-1-2016
583-030-0052	2-19-2016	Adopt	4-1-2016
583-030-0052(T)	2-19-2016	Repeal	4-1-2016
583-030-0053	2-19-2016	Adopt	4-1-2016
583-030-0053(T)	2-19-2016	Repeal	4-1-2016
583-030-0054	2-19-2016	Adopt	4-1-2016
583-030-0054(T)	2-19-2016	Repeal	4-1-2016
583-030-0056	2-19-2016	Adopt	4-1-2016
583-030-0056(T)	2-19-2016	Repeal	4-1-2016
583-050-0006	2-19-2016	Amend	4-1-2016
583-050-0006(T)	2-19-2016	Repeal	4-1-2016
583-050-0011	2-19-2016	Amend	4-1-2016
583-050-0011(T)	2-19-2016	Repeal	4-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
583-050-0014	2-19-2016	Amend	4-1-2016
583-050-0014(T)	2-19-2016	Repeal	4-1-2016
583-050-0016	2-19-2016	Amend	4-1-2016
583-050-0016(T)	2-19-2016	Repeal	4-1-2016
583-050-0026	2-19-2016	Amend	4-1-2016
583-050-0026(T)	2-19-2016	Repeal	4-1-2016
583-050-0027	2-19-2016	Amend	4-1-2016
583-050-0027(T)	2-19-2016	Repeal	4-1-2016
583-050-0028	2-19-2016	Amend	4-1-2016
583-050-0028(T)	2-19-2016	Repeal	4-1-2016
583-050-0036	2-19-2016	Amend	4-1-2016
583-050-0036(T)	2-19-2016	Repeal	4-1-2016
583-050-0040	2-19-2016	Amend	4-1-2016
583-050-0040(T)	2-19-2016	Repeal	4-1-2016
584-010-0004	7-1-2016	Adopt(T)	8-1-2016
584-010-0090	1-1-2016	Suspend	2-1-2016
584-010-0125	7-1-2016	Adopt(T)	8-1-2016
584-017-1100	2-10-2016	Adopt	3-1-2016
584-018-0110	1-1-2016	Suspend	2-1-2016
584-018-0110	4-15-2016	Repeal	5-1-2016
584-020-0060	7-1-2016	Amend(T)	8-1-2016
584-040-0005	2-10-2016	Repeal	3-1-2016
584-040-0008	2-10-2016	Repeal	3-1-2016
584-040-0010	2-10-2016	Repeal	3-1-2016
584-040-0030	2-10-2016	Repeal	3-1-2016
584-040-0040	2-10-2016	Repeal	3-1-2016
584-040-0050	2-10-2016	Repeal	3-1-2016
584-040-0060	2-10-2016	Repeal	3-1-2016
584-040-0080	2-10-2016	Repeal	3-1-2016
584-040-0090	2-10-2016	Repeal	3-1-2016
584-040-0100	2-10-2016	Repeal	3-1-2016
584-040-0120	2-10-2016	Repeal	3-1-2016
584-040-0130	2-10-2016	Repeal	3-1-2016
584-040-0150	2-10-2016	Repeal	3-1-2016
584-040-0160	2-10-2016	Repeal	3-1-2016
584-040-0165	2-10-2016	Repeal	3-1-2016
584-040-0170	2-10-2016	Repeal	3-1-2016
584-040-0180	2-10-2016	Repeal	3-1-2016
584-040-0200	2-10-2016	Repeal	3-1-2016
584-040-0210	2-10-2016	Repeal	3-1-2016
584-040-0230	2-10-2016	Repeal	3-1-2016
584-040-0240	2-10-2016	Repeal	3-1-2016
584-040-0241	2-10-2016	Repeal	3-1-2016
584-040-0242	2-10-2016	Repeal	3-1-2016
584-040-0243	2-10-2016	Repeal	3-1-2016
584-040-0250	2-10-2016	Repeal	3-1-2016
584-040-0260	2-10-2016	Repeal	3-1-2016
584-040-0265	2-10-2016	Repeal	3-1-2016
584-040-0270	2-10-2016	Repeal	3-1-2016
584-040-0280	2-10-2016	Repeal	3-1-2016
584-040-0290	2-10-2016	Repeal	3-1-2016
584-040-0300	2-10-2016	Repeal	3-1-2016
584-040-0310	2-10-2016	Repeal	3-1-2016
584-040-0315	2-10-2016	Repeal	3-1-2016
584-040-0350	2-10-2016	Repeal	3-1-2016
584-050-0150	2-10-2016	Adopt	3-1-2016
584-052-0005	2-10-2016	Repeal	3-1-2016
584-052-0010	2-10-2016	Repeal	3-1-2016
584-052-0015	2-10-2016	Repeal	3-1-2016
584-052-0021	2-10-2016	Repeal	3-1-2016
584-052-0025	2-10-2016	Repeal	3-1-2016
584-052-0027	2-10-2016	Repeal	3-1-2016
584-065-0001	2-10-2016	Repeal	3-1-2016
584-065-0060	2-10-2016	Repeal	3-1-2016
584-065-0070	2-10-2016	Repeal	3-1-2016
584-065-0080	2-10-2016	Repeal	3-1-2016
584-065-0090	2-10-2016	Repeal	3-1-2016
584-065-0120	2-10-2016	Repeal	3-1-2016
584-065-0125	2-10-2016	Repeal	3-1-2016
584-066-0001	2-10-2016	Repeal	3-1-2016
584-066-0010	2-10-2016	Repeal	3-1-2016
584-066-0015	2-10-2016	Repeal	3-1-2016
584-066-0020	2-10-2016	Repeal	3-1-2016
584-066-0025	2-10-2016	Repeal	3-1-2016
584-066-0030	2-10-2016	Repeal	3-1-2016
584-070-0012	2-10-2016	Amend	3-1-2016
584-070-0014	2-10-2016	Repeal	3-1-2016
584-070-0510	2-10-2016	Adopt	3-1-2016
584-100-0002	4-15-2016	Repeal	5-1-2016
584-100-0006	4-15-2016	Repeal	5-1-2016
584-100-0007	4-15-2016	Repeal	5-1-2016
584-100-0008	4-15-2016	Repeal	5-1-2016
584-100-0011	4-15-2016	Repeal	5-1-2016
584-100-0016	4-15-2016	Repeal	5-1-2016
584-100-0017	4-15-2016	Repeal	5-1-2016
584-100-0021	4-15-2016	Repeal	5-1-2016
584-100-0026	4-15-2016	Repeal	5-1-2016
584-100-0031	4-15-2016	Repeal	5-1-2016
584-100-0036	4-15-2016	Repeal	5-1-2016
584-100-0038	4-15-2016	Repeal	5-1-2016
584-100-0041	4-15-2016	Repeal	5-1-2016
584-100-0051	4-15-2016	Repeal	5-1-2016
584-100-0056	4-15-2016	Repeal	5-1-2016
584-100-0061	4-15-2016	Repeal	5-1-2016
584-100-0066	4-15-2016	Repeal	5-1-2016
584-100-0071	4-15-2016	Repeal	5-1-2016
584-100-0091	4-15-2016	Repeal	5-1-2016
584-100-0096	4-15-2016	Repeal	5-1-2016
584-100-0111	4-15-2016	Repeal	5-1-2016
584-200-0004	1-1-2016	Adopt(T)	2-1-2016
584-200-0005	2-10-2016	Adopt	3-1-2016
584-200-0005	7-1-2016	Amend(T)	8-1-2016
584-200-0010	1-1-2016	Amend(T)	2-1-2016
584-200-0010	2-10-2016	Adopt	3-1-2016
584-200-0020	2-10-2016	Adopt	3-1-2016
584-200-0030	2-10-2016	Adopt	3-1-2016
584-200-0030	7-1-2016	Amend(T)	8-1-2016
584-200-0040	2-10-2016	Adopt	3-1-2016
584-200-0050	1-1-2016	Amend(T)	2-1-2016
584-200-0050	2-10-2016	Adopt	3-1-2016
584-200-0060	2-10-2016	Adopt	3-1-2016
584-200-0070	2-10-2016	Adopt	3-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
584-200-0080	2-10-2016	Adopt	3-1-2016
584-200-0090	2-10-2016	Adopt	3-1-2016
584-200-0100	2-10-2016	Adopt	3-1-2016
584-210-0030	2-10-2016	Amend	3-1-2016
584-210-0040	2-10-2016	Amend	3-1-2016
584-210-0050	2-10-2016	Amend	3-1-2016
584-210-0050	7-1-2016	Amend(T)	8-1-2016
584-210-0060	2-10-2016	Amend	3-1-2016
584-210-0070	2-10-2016	Amend	3-1-2016
584-210-0080	2-10-2016	Amend	3-1-2016
584-210-0090	2-10-2016	Amend	3-1-2016
584-210-0100	2-10-2016	Amend	3-1-2016
584-210-0110	2-10-2016	Amend	3-1-2016
584-210-0120	4-15-2016	Repeal	5-1-2016
584-210-0130	2-10-2016	Amend	3-1-2016
584-210-0140	2-10-2016	Amend	3-1-2016
584-210-0150	2-10-2016	Amend	3-1-2016
584-210-0160	2-10-2016	Amend	3-1-2016
584-210-0165	2-10-2016	Adopt	3-1-2016
584-210-0190	2-10-2016	Amend	3-1-2016
584-220-0010	2-10-2016	Amend	3-1-2016
584-220-0015	2-10-2016	Amend	3-1-2016
584-220-0020	2-10-2016	Amend	3-1-2016
584-220-0025	2-10-2016	Amend	3-1-2016
584-220-0030	2-10-2016	Amend	3-1-2016
584-220-0035	2-10-2016	Amend	3-1-2016
584-220-0040	2-10-2016	Amend	3-1-2016
584-220-0045	2-10-2016	Amend	3-1-2016
584-220-0050	2-10-2016	Amend	3-1-2016
584-220-0055	2-10-2016	Amend	3-1-2016
584-220-0060	2-10-2016	Amend	3-1-2016
584-220-0065	2-10-2016	Amend	3-1-2016
584-220-0070	2-10-2016	Amend	3-1-2016
584-220-0075	2-10-2016	Amend	3-1-2016
584-220-0080	2-10-2016	Amend	3-1-2016
584-220-0085	2-10-2016	Amend	3-1-2016
584-220-0090	2-10-2016	Amend	3-1-2016
584-220-0095	2-10-2016	Amend	3-1-2016
584-220-0100	2-10-2016	Amend	3-1-2016
584-220-0105	2-10-2016	Amend	3-1-2016
584-220-0110	2-10-2016	Amend	3-1-2016
584-220-0120	2-10-2016	Amend	3-1-2016
584-220-0130	2-10-2016	Amend	3-1-2016
584-220-0140	2-10-2016	Amend	3-1-2016
584-220-0145	2-10-2016	Amend	3-1-2016
584-220-0150	2-10-2016	Amend	3-1-2016
584-220-0155	2-10-2016	Amend	3-1-2016
584-220-0160	2-10-2016	Amend	3-1-2016
584-220-0165	2-10-2016	Amend	3-1-2016
584-220-0170	2-10-2016	Amend	3-1-2016
584-220-0175	2-10-2016	Amend	3-1-2016
584-220-0180	2-10-2016	Amend	3-1-2016
584-220-0185	2-10-2016	Amend	3-1-2016
584-220-0190	2-10-2016	Amend	3-1-2016
584-220-0195	2-10-2016	Amend	3-1-2016
584-220-0200	2-10-2016	Amend	3-1-2016
584-220-0205	2-10-2016	Amend	3-1-2016
584-220-0210	2-10-2016	Amend	3-1-2016
584-220-0215	2-10-2016	Amend	3-1-2016
584-220-0220	2-10-2016	Amend	3-1-2016
584-220-0225	2-10-2016	Amend	3-1-2016
584-220-0230	2-10-2016	Amend	3-1-2016
584-225-0010	2-10-2016	Adopt	3-1-2016
584-225-0020	2-10-2016	Adopt	3-1-2016
584-225-0030	2-10-2016	Adopt	3-1-2016
584-225-0040	2-10-2016	Adopt	3-1-2016
584-225-0050	2-10-2016	Adopt	3-1-2016
584-225-0070	2-10-2016	Adopt	3-1-2016
584-225-0090	2-10-2016	Adopt	3-1-2016
584-225-0100	2-10-2016	Adopt	3-1-2016
584-255-0010	2-10-2016	Amend	3-1-2016
584-255-0030	2-10-2016	Amend	3-1-2016
584-420-0010	2-10-2016	Adopt	3-1-2016
584-420-0020	2-10-2016	Adopt	3-1-2016
584-420-0030	2-10-2016	Adopt	3-1-2016
584-420-0040	2-10-2016	Adopt	3-1-2016
584-420-0300	2-10-2016	Adopt	3-1-2016
584-420-0310	2-10-2016	Adopt	3-1-2016
584-420-0345	2-10-2016	Adopt	3-1-2016
584-420-0360	2-10-2016	Adopt	3-1-2016
584-420-0365	2-10-2016	Adopt	3-1-2016
584-420-0375	2-10-2016	Adopt	3-1-2016
584-420-0390	2-10-2016	Adopt	3-1-2016
584-420-0415	2-10-2016	Adopt	3-1-2016
584-420-0420	2-10-2016	Adopt	3-1-2016
584-420-0425	2-10-2016	Adopt	3-1-2016
584-420-0440	2-10-2016	Adopt	3-1-2016
584-420-0460	2-10-2016	Adopt	3-1-2016
584-420-0475	2-10-2016	Adopt	3-1-2016
584-420-0490	2-10-2016	Adopt	3-1-2016
584-420-0600	2-10-2016	Adopt	3-1-2016
584-420-0610	2-10-2016	Adopt	3-1-2016
584-420-0620	2-10-2016	Adopt	3-1-2016
584-420-0630	2-10-2016	Adopt	3-1-2016
584-420-0640	2-10-2016	Adopt	3-1-2016
584-420-0650	2-10-2016	Adopt	3-1-2016
584-420-0660	2-10-2016	Adopt	3-1-2016
589-002-0120	2-12-2016	Amend	3-1-2016
603-011-0212	4-5-2016	Amend	5-1-2016
603-012-0210	4-29-2016	Amend	6-1-2016
603-012-0220	4-29-2016	Amend	6-1-2016
603-012-0230	4-29-2016	Amend	6-1-2016
603-012-0240	4-29-2016	Amend	6-1-2016
603-012-0250	4-29-2016	Adopt	6-1-2016
603-024-0017	6-20-2016	Amend	8-1-2016
603-024-0041	6-20-2016	Amend	8-1-2016
603-024-0211	6-20-2016	Amend	8-1-2016
603-024-0594	6-20-2016	Amend	8-1-2016
603-024-0641	6-20-2016	Amend	8-1-2016
603-025-0150	2-9-2016	Amend	3-1-2016
603-025-0151	2-9-2016	Adopt	3-1-2016
603-025-0152	2-9-2016	Adopt	3-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
603-025-0190	12-2-2015	Amend	1-1-2016
603-025-0315	5-19-2016	Adopt	7-1-2016
603-025-0320	5-19-2016	Adopt	7-1-2016
603-025-0325	5-19-2016	Adopt	7-1-2016
603-025-0330	5-19-2016	Adopt	7-1-2016
603-048-0010	5-3-2016	Amend(T)	6-1-2016
603-048-0050	5-3-2016	Suspend	6-1-2016
603-048-0100	5-3-2016	Amend(T)	6-1-2016
603-048-0110	5-3-2016	Suspend	6-1-2016
603-048-0200	1-29-2016	Amend(T)	3-1-2016
603-048-0200	5-3-2016	Amend(T)	6-1-2016
603-048-0250	5-3-2016	Suspend	6-1-2016
603-048-0300	5-3-2016	Amend(T)	6-1-2016
603-048-0400	5-3-2016	Amend(T)	6-1-2016
603-048-0500	5-3-2016	Amend(T)	6-1-2016
603-048-0600	1-29-2016	Amend(T)	3-1-2016
603-048-0600	5-3-2016	Amend(T)	6-1-2016
603-048-0650	5-3-2016	Adopt(T)	6-1-2016
603-048-0700	5-3-2016	Amend(T)	6-1-2016
603-048-0800	5-3-2016	Amend(T)	6-1-2016
603-048-0900	5-3-2016	Amend(T)	6-1-2016
603-048-1000	5-3-2016	Amend(T)	6-1-2016
603-052-0052	11-18-2015	Adopt(T)	1-1-2016
603-052-0347	2-12-2016	Amend	3-1-2016
603-052-0385	2-12-2016	Amend	3-1-2016
603-054-0014	4-29-2016	Adopt	6-1-2016
603-054-0016	4-29-2016	Amend	6-1-2016
603-054-0017	4-29-2016	Amend	6-1-2016
603-054-0018	4-29-2016	Amend	6-1-2016
603-055-0100	4-5-2016	Amend	5-1-2016
603-055-0200	4-5-2016	Adopt	5-1-2016
603-056-0095	4-15-2016	Amend	5-1-2016
603-057-0107	1-1-2016	Adopt(T)	1-1-2016
603-057-0108	6-28-2016	Adopt	8-1-2016
603-057-0155	1-1-2016	Adopt(T)	1-1-2016
603-057-0157	1-1-2016	Adopt(T)	1-1-2016
603-057-0502	2-26-2016	Amend	4-1-2016
603-057-0529	2-26-2016	Adopt	4-1-2016
603-057-0530	2-26-2016	Amend	4-1-2016
603-057-0531	2-26-2016	Adopt	4-1-2016
603-057-0532	2-26-2016	Amend	4-1-2016
603-059-0020	7-1-2016	Amend	8-1-2016
603-059-0030	7-1-2016	Amend	8-1-2016
603-059-0050	7-1-2016	Amend	8-1-2016
603-059-0055	7-1-2016	Amend	8-1-2016
603-059-0060	7-1-2016	Adopt	8-1-2016
603-059-0070	7-1-2016	Amend	8-1-2016
603-059-0080	7-1-2016	Amend	8-1-2016
611-030-0010	5-9-2016	Amend	6-1-2016
623-010-0010	9-1-2016	Amend	7-1-2016
629-025-0000	3-11-2016	Amend	4-1-2016
629-025-0005	3-11-2016	Amend	4-1-2016
629-025-0011	3-11-2016	Amend	4-1-2016
629-025-0020	3-11-2016	Amend	4-1-2016
629-025-0021	3-11-2016	Adopt	4-1-2016
629-025-0022	3-11-2016	Adopt	4-1-2016
629-025-0030	3-11-2016	Amend	4-1-2016
629-025-0040	3-11-2016	Amend	4-1-2016
629-025-0050	3-11-2016	Amend	4-1-2016
629-025-0060	3-11-2016	Amend	4-1-2016
629-025-0070	3-11-2016	Amend	4-1-2016
629-025-0080	3-11-2016	Amend	4-1-2016
629-025-0090	3-11-2016	Adopt	4-1-2016
629-025-0098	3-11-2016	Adopt	4-1-2016
629-025-0099	3-11-2016	Adopt	4-1-2016
629-170-0001	7-1-2016	Adopt	7-1-2016
629-170-0005	7-1-2016	Adopt	7-1-2016
629-170-0010	7-1-2016	Adopt	7-1-2016
629-170-0015	7-1-2016	Adopt	7-1-2016
629-170-0020	7-1-2016	Adopt	7-1-2016
629-170-0025	7-1-2016	Adopt	7-1-2016
629-170-0030	7-1-2016	Adopt	7-1-2016
629-170-0035	7-1-2016	Adopt	7-1-2016
629-170-0040	7-1-2016	Adopt	7-1-2016
632-030-0016	1-14-2016	Amend(T)	2-1-2016
632-030-0016	6-27-2016	Amend	8-1-2016
632-030-0016(T)	6-27-2016	Repeal	8-1-2016
632-030-0022	1-14-2016	Amend(T)	2-1-2016
632-030-0022	6-27-2016	Amend	8-1-2016
632-030-0022(T)	6-27-2016	Repeal	8-1-2016
635-001-0030	12-9-2015	Adopt	1-1-2016
635-001-0210	4-27-2016	Amend	6-1-2016
635-001-0341	1-6-2016	Adopt	2-1-2016
635-003-0003	4-25-2016	Amend	6-1-2016
635-003-0085	4-25-2016	Amend	6-1-2016
635-004-0215	1-19-2016	Amend	3-1-2016
635-004-0275	11-25-2015	Amend(T)	1-1-2016
635-004-0275	1-19-2016	Amend	3-1-2016
635-004-0275	7-5-2016	Amend(T)	8-1-2016
635-004-0275(T)	11-25-2015	Suspend	1-1-2016
635-004-0295	1-19-2016	Amend	3-1-2016
635-004-0300	1-19-2016	Amend	3-1-2016
635-004-0340	1-19-2016	Amend	3-1-2016
635-004-0350	1-19-2016	Amend	3-1-2016
635-004-0355	1-19-2016	Amend	3-1-2016
635-004-0355	7-5-2016	Amend(T)	8-1-2016
635-004-0360	1-19-2016	Amend	3-1-2016
635-004-0370	6-13-2016	Amend	7-1-2016
635-004-0375	7-1-2016	Amend(T)	8-1-2016
635-004-0377	6-13-2016	Adopt	7-1-2016
635-004-0378	6-13-2016	Adopt	7-1-2016
635-004-0379	6-13-2016	Adopt	7-1-2016
635-004-0425	6-13-2016	Repeal	7-1-2016
635-004-0430	6-13-2016	Amend	7-1-2016
635-004-0435	6-13-2016	Repeal	7-1-2016
635-004-0440	6-13-2016	Repeal	7-1-2016
635-004-0555	6-13-2016	Amend	7-1-2016
635-004-0585	4-26-2016	Amend	6-1-2016
635-005-0290	1-1-2016	Amend	1-1-2016
635-005-0305	1-1-2016	Amend	1-1-2016
635-005-0310	1-1-2016	Amend	1-1-2016
635-005-0350	1-1-2016	Amend	1-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
635-005-0355	1-1-2016	Amend	1-1-2016
635-005-0355	2-23-2016	Amend(T)	4-1-2016
635-005-0385	1-1-2016	Amend	1-1-2016
635-005-0387	1-1-2016	Adopt	1-1-2016
635-005-0465	11-20-2015	Amend(T)	1-1-2016
635-005-0465	1-1-2016	Amend(T)	2-1-2016
635-005-0465(T)	1-1-2016	Suspend	2-1-2016
635-005-0790	4-1-2016	Amend	5-1-2016
635-005-0795	4-1-2016	Amend	5-1-2016
635-005-0800	4-1-2016	Amend	5-1-2016
635-005-0805	4-1-2016	Amend	5-1-2016
635-005-0810	4-1-2016	Amend	5-1-2016
635-005-0815	4-1-2016	Amend	5-1-2016
635-005-0820	4-1-2016	Amend	5-1-2016
635-005-0825	4-1-2016	Amend	5-1-2016
635-005-0830	4-1-2016	Amend	5-1-2016
635-005-0835	4-1-2016	Amend	5-1-2016
635-005-0840	4-1-2016	Amend	5-1-2016
635-005-0845	4-1-2016	Amend	5-1-2016
635-005-0920	6-3-2016	Amend(T)	7-1-2016
635-005-0931	6-13-2016	Adopt	7-1-2016
635-005-0932	6-13-2016	Adopt	7-1-2016
635-005-0933	6-13-2016	Adopt	7-1-2016
635-006-0136	6-13-2016	Adopt	7-1-2016
635-006-0210	2-1-2016	Amend(T)	3-1-2016
635-006-0210	7-29-2016	Amend(T)	8-1-2016
635-006-0210(T)	7-29-2016	Suspend	8-1-2016
635-006-0212	5-18-2016	Amend(T)	7-1-2016
635-006-0215	5-18-2016	Amend(T)	7-1-2016
635-006-0225	5-18-2016	Amend(T)	7-1-2016
635-006-0232	1-19-2016	Amend	3-1-2016
635-007-0605	2-23-2016	Amend(T)	4-1-2016
635-008-0053	4-27-2016	Amend	6-1-2016
635-008-0068	4-27-2016	Amend	6-1-2016
635-008-0080	4-27-2016	Amend	6-1-2016
635-008-0095	4-27-2016	Amend	6-1-2016
635-008-0112	6-27-2016	Adopt	8-1-2016
635-008-0115	4-27-2016	Amend	6-1-2016
635-008-0120	4-27-2016	Amend	6-1-2016
635-008-0123	11-25-2015	Amend	1-1-2016
635-008-0123(T)	11-25-2015	Repeal	1-1-2016
635-008-0147	4-27-2016	Amend	6-1-2016
635-008-0155	4-27-2016	Amend	6-1-2016
635-008-0190	4-27-2016	Amend	6-1-2016
635-010-0015	11-25-2015	Amend	1-1-2016
635-011-0100	1-1-2016	Amend	2-1-2016
635-011-0100	4-1-2016	Amend(T)	5-1-2016
635-012-0090	6-13-2016	Amend	7-1-2016
635-012-0100	6-13-2016	Amend	7-1-2016
635-013-0003	4-25-2016	Amend	6-1-2016
635-013-0004	1-1-2016	Amend	2-1-2016
635-013-0007	4-25-2016	Amend	6-1-2016
635-014-0080	1-1-2016	Amend	2-1-2016
635-014-0090	1-1-2016	Amend	2-1-2016
635-014-0090	4-1-2016	Amend(T)	5-1-2016
635-014-0090	5-1-2016	Amend(T)	6-1-2016
635-014-0090(T)	5-1-2016	Suspend	6-1-2016
635-016-0080	1-1-2016	Amend	2-1-2016
635-016-0090	1-1-2016	Amend	2-1-2016
635-016-0090	4-1-2016	Amend(T)	5-1-2016
635-016-0090	5-11-2016	Amend(T)	6-1-2016
635-016-0090(T)	5-11-2016	Suspend	6-1-2016
635-017-0080	1-1-2016	Amend	2-1-2016
635-017-0090	1-1-2016	Amend	2-1-2016
635-017-0090	4-1-2016	Amend(T)	5-1-2016
635-017-0090	4-8-2016	Amend(T)	5-1-2016
635-017-0090	6-9-2016	Amend(T)	7-1-2016
635-017-0090	6-16-2016	Amend(T)	7-1-2016
635-017-0090(T)	4-8-2016	Suspend	5-1-2016
635-017-0090(T)	6-9-2016	Suspend	7-1-2016
635-017-0090(T)	6-16-2016	Suspend	7-1-2016
635-017-0095	1-1-2016	Amend	2-1-2016
635-018-0080	1-1-2016	Amend	2-1-2016
635-018-0090	1-1-2016	Amend	2-1-2016
635-018-0090	4-15-2016	Amend(T)	5-1-2016
635-019-0080	1-1-2016	Amend	2-1-2016
635-019-0090	1-1-2016	Amend	2-1-2016
635-019-0090	5-10-2016	Amend(T)	6-1-2016
635-019-0090	5-28-2016	Amend(T)	7-1-2016
635-019-0090	6-15-2016	Amend(T)	7-1-2016
635-019-0090	7-2-2016	Amend(T)	8-1-2016
635-019-0090	7-3-2016	Amend(T)	8-1-2016
635-019-0090(T)	5-28-2016	Suspend	7-1-2016
635-019-0090(T)	6-15-2016	Suspend	7-1-2016
635-019-0090(T)	7-2-2016	Suspend	8-1-2016
635-019-0090(T)	7-3-2016	Suspend	8-1-2016
635-021-0080	1-1-2016	Amend	2-1-2016
635-021-0090	1-1-2016	Amend	2-1-2016
635-021-0090	4-1-2016	Amend(T)	5-1-2016
635-021-0090	5-1-2016	Amend(T)	6-1-2016
635-021-0090	6-8-2016	Amend(T)	7-1-2016
635-021-0090(T)	5-1-2016	Suspend	6-1-2016
635-021-0090(T)	6-8-2016	Suspend	7-1-2016
635-023-0080	1-1-2016	Amend	2-1-2016
635-023-0090	1-1-2016	Amend	2-1-2016
635-023-0095	1-1-2016	Amend	2-1-2016
635-023-0095	2-8-2016	Amend(T)	3-1-2016
635-023-0095	4-30-2016	Amend(T)	6-1-2016
635-023-0095	5-1-2016	Amend(T)	6-1-2016
635-023-0095	5-29-2016	Amend(T)	7-1-2016
635-023-0095	6-30-2016	Amend(T)	8-1-2016
635-023-0095(T)	4-30-2016	Suspend	6-1-2016
635-023-0095(T)	5-1-2016	Suspend	6-1-2016
635-023-0095(T)	5-29-2016	Suspend	7-1-2016
635-023-0095(T)	6-30-2016	Suspend	8-1-2016
635-023-0125	1-1-2016	Amend	2-1-2016
635-023-0125	3-1-2016	Amend(T)	3-1-2016
635-023-0125	4-8-2016	Amend(T)	5-1-2016
635-023-0125	5-6-2016	Amend(T)	6-1-2016
635-023-0125	5-13-2016	Amend(T)	6-1-2016
635-023-0125	5-20-2016	Amend(T)	7-1-2016
635-023-0125	5-28-2016	Amend(T)	7-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
635-023-0125	6-10-2016	Amend(T)	7-1-2016
635-023-0125	6-10-2016	Suspend	7-1-2016
635-023-0125(T)	4-8-2016	Suspend	5-1-2016
635-023-0125(T)	5-6-2016	Suspend	6-1-2016
635-023-0125(T)	5-13-2016	Suspend	6-1-2016
635-023-0125(T)	5-20-2016	Suspend	7-1-2016
635-023-0125(T)	5-28-2016	Suspend	7-1-2016
635-023-0128	1-1-2016	Amend	2-1-2016
635-023-0128	6-16-2016	Amend(T)	7-1-2016
635-023-0130	1-1-2016	Amend	2-1-2016
635-023-0134	1-1-2016	Amend	2-1-2016
635-023-0134	4-23-2016	Amend(T)	5-1-2016
635-023-0134	6-2-2016	Amend(T)	7-1-2016
635-023-0134(T)	6-2-2016	Suspend	7-1-2016
635-023-0140	1-1-2016	Amend	2-1-2016
635-039-0080	1-1-2016	Amend	2-1-2016
635-039-0080	1-19-2016	Amend	3-1-2016
635-039-0085	4-26-2016	Amend	6-1-2016
635-039-0085	6-2-2016	Amend(T)	7-1-2016
635-039-0085	6-8-2016	Amend(T)	7-1-2016
635-039-0085(T)	6-8-2016	Suspend	7-1-2016
635-039-0090	1-1-2016	Amend	2-1-2016
635-039-0090	1-19-2016	Amend	3-1-2016
635-039-0090	4-1-2016	Amend(T)	5-1-2016
635-039-0090	4-26-2016	Amend	6-1-2016
635-039-0090	4-26-2016	Amend(T)	6-1-2016
635-039-0090	7-14-2016	Amend(T)	8-1-2016
635-039-0090(T)	4-26-2016	Repeal	6-1-2016
635-039-0090(T)	7-14-2016	Suspend	8-1-2016
635-041-0045	6-16-2016	Amend(T)	7-1-2016
635-041-0065	2-1-2016	Amend(T)	3-1-2016
635-041-0065	2-12-2016	Amend(T)	3-1-2016
635-041-0065	2-19-2016	Amend(T)	4-1-2016
635-041-0065	2-26-2016	Amend(T)	4-1-2016
635-041-0065	3-5-2016	Amend(T)	4-1-2016
635-041-0065	5-16-2016	Amend(T)	6-1-2016
635-041-0065	5-25-2016	Amend(T)	7-1-2016
635-041-0065	6-6-2016	Amend(T)	7-1-2016
635-041-0065(T)	2-12-2016	Suspend	3-1-2016
635-041-0065(T)	2-19-2016	Suspend	4-1-2016
635-041-0065(T)	2-26-2016	Suspend	4-1-2016
635-041-0065(T)	3-5-2016	Suspend	4-1-2016
635-041-0065(T)	5-25-2016	Suspend	7-1-2016
635-041-0065(T)	6-6-2016	Suspend	7-1-2016
635-041-0076	6-16-2016	Amend(T)	7-1-2016
635-041-0076	7-5-2016	Amend(T)	8-1-2016
635-041-0076	7-11-2016	Amend(T)	8-1-2016
635-041-0076	7-18-2016	Amend(T)	8-1-2016
635-041-0076(T)	7-5-2016	Suspend	8-1-2016
635-041-0076(T)	7-11-2016	Suspend	8-1-2016
635-041-0076(T)	7-18-2016	Suspend	8-1-2016
635-041-0610	4-25-2016	Adopt	6-1-2016
635-042-0022	3-28-2016	Amend(T)	5-1-2016
635-042-0022	4-5-2016	Amend(T)	5-1-2016
635-042-0022	5-11-2016	Amend(T)	6-1-2016
635-042-0022	5-23-2016	Amend(T)	7-1-2016
635-042-0022	5-31-2016	Amend(T)	7-1-2016
635-042-0022	6-7-2016	Amend(T)	7-1-2016
635-042-0022(T)	4-5-2016	Suspend	5-1-2016
635-042-0022(T)	5-11-2016	Suspend	6-1-2016
635-042-0022(T)	5-23-2016	Suspend	7-1-2016
635-042-0022(T)	5-31-2016	Suspend	7-1-2016
635-042-0022(T)	6-7-2016	Suspend	7-1-2016
635-042-0027	6-16-2016	Amend(T)	7-1-2016
635-042-0027	7-11-2016	Amend(T)	8-1-2016
635-042-0027(T)	7-11-2016	Suspend	8-1-2016
635-042-0130	2-1-2016	Amend(T)	3-1-2016
635-042-0145	2-8-2016	Amend(T)	3-1-2016
635-042-0145	3-28-2016	Amend(T)	5-1-2016
635-042-0145	4-6-2016	Amend(T)	5-1-2016
635-042-0145	4-13-2016	Amend(T)	5-1-2016
635-042-0145	4-21-2016	Amend(T)	6-1-2016
635-042-0145	5-11-2016	Amend(T)	6-1-2016
635-042-0145	5-23-2016	Amend(T)	7-1-2016
635-042-0145	5-31-2016	Amend(T)	7-1-2016
635-042-0145	6-7-2016	Amend(T)	7-1-2016
635-042-0145(T)	3-28-2016	Suspend	5-1-2016
635-042-0145(T)	4-6-2016	Suspend	5-1-2016
635-042-0145(T)	4-13-2016	Suspend	5-1-2016
635-042-0145(T)	4-21-2016	Suspend	6-1-2016
635-042-0145(T)	5-11-2016	Suspend	6-1-2016
635-042-0145(T)	5-23-2016	Suspend	7-1-2016
635-042-0145(T)	5-31-2016	Suspend	7-1-2016
635-042-0145(T)	6-7-2016	Suspend	7-1-2016
635-042-0160	2-8-2016	Amend(T)	3-1-2016
635-042-0160	3-28-2016	Amend(T)	5-1-2016
635-042-0160	4-21-2016	Amend(T)	6-1-2016
635-042-0160	6-16-2016	Amend(T)	7-1-2016
635-042-0160	6-23-2016	Amend(T)	8-1-2016
635-042-0160	6-30-2016	Amend(T)	8-1-2016
635-042-0160	7-7-2016	Amend(T)	8-1-2016
635-042-0160	7-14-2016	Amend(T)	8-1-2016
635-042-0160(T)	3-28-2016	Suspend	5-1-2016
635-042-0160(T)	4-21-2016	Suspend	6-1-2016
635-042-0160(T)	6-16-2016	Suspend	7-1-2016
635-042-0160(T)	6-23-2016	Suspend	8-1-2016
635-042-0160(T)	6-30-2016	Suspend	8-1-2016
635-042-0160(T)	7-7-2016	Suspend	8-1-2016
635-042-0160(T)	7-14-2016	Suspend	8-1-2016
635-042-0170	2-8-2016	Amend(T)	3-1-2016
635-042-0170	4-21-2016	Amend(T)	6-1-2016
635-042-0170	6-16-2016	Amend(T)	7-1-2016
635-042-0170	6-23-2016	Amend(T)	8-1-2016
635-042-0170	6-30-2016	Amend(T)	8-1-2016
635-042-0170	7-7-2016	Amend(T)	8-1-2016
635-042-0170	7-14-2016	Amend(T)	8-1-2016
635-042-0170(T)	4-21-2016	Suspend	6-1-2016
635-042-0170(T)	6-16-2016	Suspend	7-1-2016
635-042-0170(T)	6-23-2016	Suspend	8-1-2016
635-042-0170(T)	6-30-2016	Suspend	8-1-2016
635-042-0170(T)	7-7-2016	Suspend	8-1-2016
635-042-0170(T)	7-14-2016	Suspend	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
635-042-0180	2-8-2016	Amend(T)	3-1-2016
635-042-0180	3-28-2016	Amend(T)	5-1-2016
635-042-0180	4-21-2016	Amend(T)	6-1-2016
635-042-0180(T)	3-28-2016	Suspend	5-1-2016
635-042-0180(T)	4-21-2016	Suspend	6-1-2016
635-044-0200	12-9-2015	Repeal	1-1-2016
635-044-0205	12-9-2015	Repeal	1-1-2016
635-044-0210	12-9-2015	Repeal	1-1-2016
635-044-0215	12-9-2015	Repeal	1-1-2016
635-044-0240	12-9-2015	Repeal	1-1-2016
635-044-0245	12-9-2015	Repeal	1-1-2016
635-044-0250	12-9-2015	Repeal	1-1-2016
635-044-0255	12-9-2015	Repeal	1-1-2016
635-044-0280	12-9-2015	Repeal	1-1-2016
635-044-0300	12-9-2015	Repeal	1-1-2016
635-044-0305	12-9-2015	Repeal	1-1-2016
635-044-0310	12-9-2015	Repeal	1-1-2016
635-045-0000	11-25-2015	Amend	1-1-2016
635-045-0000	4-27-2016	Amend	6-1-2016
635-045-0002	11-25-2015	Amend	1-1-2016
635-047-0010	4-27-2016	Amend	6-1-2016
635-050-0047	6-14-2016	Amend	7-1-2016
635-050-0070	6-14-2016	Amend	7-1-2016
635-050-0080	6-14-2016	Amend	7-1-2016
635-050-0090	6-14-2016	Amend	7-1-2016
635-050-0100	6-14-2016	Amend	7-1-2016
635-050-0110	6-14-2016	Amend	7-1-2016
635-050-0120	6-14-2016	Amend	7-1-2016
635-050-0130	6-14-2016	Amend	7-1-2016
635-050-0140	6-14-2016	Amend	7-1-2016
635-050-0150	6-14-2016	Amend	7-1-2016
635-050-0170	6-14-2016	Amend	7-1-2016
635-050-0183	6-14-2016	Amend	7-1-2016
635-050-0189	6-14-2016	Amend	7-1-2016
635-051-0000	4-27-2016	Amend	6-1-2016
635-052-0000	4-27-2016	Amend	6-1-2016
635-053-0000	4-27-2016	Amend	6-1-2016
635-054-0000	4-27-2016	Amend	6-1-2016
635-060-0000	11-25-2015	Amend	1-1-2016
635-060-0000	4-27-2016	Amend	6-1-2016
635-060-0005	11-25-2015	Amend	1-1-2016
635-060-0018	11-25-2015	Amend	1-1-2016
635-062-0000	12-9-2015	Adopt	1-1-2016
635-062-0005	12-9-2015	Adopt	1-1-2016
635-062-0010	12-9-2015	Adopt	1-1-2016
635-062-0015	12-9-2015	Adopt	1-1-2016
635-062-0020	12-9-2015	Adopt	1-1-2016
635-062-0025	12-9-2015	Adopt	1-1-2016
635-062-0030	12-9-2015	Adopt	1-1-2016
635-062-0035	12-9-2015	Adopt	1-1-2016
635-062-0040	12-9-2015	Adopt	1-1-2016
635-062-0045	12-9-2015	Adopt	1-1-2016
635-062-0050	12-9-2015	Adopt	1-1-2016
635-062-0055	12-9-2015	Adopt	1-1-2016
635-062-0060	12-9-2015	Adopt	1-1-2016
635-065-0001	3-21-2016	Amend	5-1-2016
635-065-0001	3-25-2016	Amend(T)	5-1-2016
635-065-0001	6-27-2016	Amend	8-1-2016
635-065-0001(T)	6-27-2016	Repeal	8-1-2016
635-065-0011	3-21-2016	Amend	5-1-2016
635-065-0015	3-21-2016	Amend	5-1-2016
635-065-0090	3-21-2016	Amend	5-1-2016
635-065-0401	3-21-2016	Amend	5-1-2016
635-065-0625	3-21-2016	Amend	5-1-2016
635-065-0720	3-21-2016	Amend	5-1-2016
635-065-0735	3-21-2016	Amend	5-1-2016
635-065-0740	3-21-2016	Amend	5-1-2016
635-065-0760	3-21-2016	Amend	5-1-2016
635-065-0760	6-27-2016	Amend	8-1-2016
635-065-0765	2-25-2016	Amend(T)	4-1-2016
635-065-0765	3-21-2016	Amend	5-1-2016
635-065-0765	6-27-2016	Amend	8-1-2016
635-065-0765(T)	6-27-2016	Repeal	8-1-2016
635-066-0000	3-21-2016	Amend	5-1-2016
635-066-0010	6-27-2016	Amend	8-1-2016
635-067-0000	3-21-2016	Amend	5-1-2016
635-067-0000	6-27-2016	Amend	8-1-2016
635-067-0027	12-1-2015	Amend(T)	1-1-2016
635-067-0030	3-21-2016	Amend	5-1-2016
635-067-0036	3-21-2016	Adopt	5-1-2016
635-068-0000	3-21-2016	Amend	5-1-2016
635-068-0000	6-27-2016	Amend	8-1-2016
635-069-0000	3-21-2016	Amend	5-1-2016
635-069-0000	6-27-2016	Amend	8-1-2016
635-070-0000	4-6-2016	Amend	5-1-2016
635-070-0000	6-27-2016	Amend	8-1-2016
635-071-0000	4-6-2016	Amend	5-1-2016
635-071-0000	6-27-2016	Amend	8-1-2016
635-072-0000	3-21-2016	Amend	5-1-2016
635-073-0000	3-21-2016	Amend	5-1-2016
635-073-0000	5-10-2016	Amend(T)	6-1-2016
635-073-0000	6-27-2016	Amend	8-1-2016
635-073-0000(T)	6-27-2016	Repeal	8-1-2016
635-073-0100	3-21-2016	Adopt	5-1-2016
635-073-0100	6-27-2016	Amend	8-1-2016
635-075-0020	3-21-2016	Amend	5-1-2016
635-075-0022	6-27-2016	Amend	8-1-2016
635-075-0025	3-21-2016	Amend	5-1-2016
635-075-0026	3-21-2016	Amend	5-1-2016
635-200-0020	6-13-2016	Amend	7-1-2016
635-200-0120	6-13-2016	Amend	7-1-2016
635-415-0025	3-25-2016	Amend	5-1-2016
635-435-0000	12-9-2015	Amend	1-1-2016
635-435-0005	12-9-2015	Amend	1-1-2016
635-435-0010	12-9-2015	Amend	1-1-2016
635-435-0010	12-9-2015	Amend(T)	1-1-2016
635-435-0010	6-14-2016	Amend	7-1-2016
635-435-0015	12-9-2015	Amend	1-1-2016
635-435-0020	12-9-2015	Amend	1-1-2016
635-435-0025	12-9-2015	Amend	1-1-2016
635-435-0030	12-9-2015	Repeal	1-1-2016
635-435-0035	12-9-2015	Repeal	1-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
635-435-0040	12-9-2015	Amend	1-1-2016
635-435-0045	12-9-2015	Amend	1-1-2016
635-435-0050	12-9-2015	Amend	1-1-2016
635-435-0055	12-9-2015	Amend	1-1-2016
635-435-0060	12-9-2015	Amend	1-1-2016
647-010-0010	7-1-2016	Amend	6-1-2016
657-010-0015	7-1-2016	Amend	7-1-2016
660-004-0018	2-10-2016	Amend	3-1-2016
660-006-0005	2-10-2016	Amend	3-1-2016
660-006-0010	2-10-2016	Amend	3-1-2016
660-006-0025	2-10-2016	Amend	3-1-2016
660-006-0026	2-10-2016	Amend	3-1-2016
660-006-0027	2-10-2016	Amend	3-1-2016
660-015-0000	1-1-2016	Amend	2-1-2016
660-023-0115	2-10-2016	Amend	3-1-2016
660-024-0000	1-1-2016	Amend	2-1-2016
660-024-0050	1-1-2016	Amend	2-1-2016
660-024-0060	1-1-2016	Amend	2-1-2016
660-024-0065	1-1-2016	Adopt	2-1-2016
660-024-0067	1-1-2016	Adopt	2-1-2016
660-024-0070	1-1-2016	Amend	2-1-2016
660-025-0020	2-10-2016	Amend	3-1-2016
660-025-0035	2-10-2016	Amend	3-1-2016
660-025-0040	2-10-2016	Amend	3-1-2016
660-025-0060	2-10-2016	Amend	3-1-2016
660-025-0085	2-10-2016	Amend	3-1-2016
660-025-0090	2-10-2016	Amend	3-1-2016
660-025-0130	2-10-2016	Amend	3-1-2016
660-025-0140	2-10-2016	Amend	3-1-2016
660-025-0150	2-10-2016	Amend	3-1-2016
660-025-0160	2-10-2016	Amend	3-1-2016
660-025-0175	2-10-2016	Amend	3-1-2016
660-027-0070	2-10-2016	Amend	3-1-2016
660-033-0020	3-24-2016	Amend	5-1-2016
660-033-0030	2-10-2016	Amend	3-1-2016
660-033-0030	3-24-2016	Amend	5-1-2016
660-033-0045	2-10-2016	Amend	3-1-2016
660-033-0100	3-24-2016	Amend	5-1-2016
660-033-0120	2-10-2016	Amend	3-1-2016
660-033-0130	2-10-2016	Amend	3-1-2016
660-033-0135	2-10-2016	Amend	3-1-2016
660-033-0150	2-10-2016	Repeal	3-1-2016
660-038-0000	1-1-2016	Adopt	2-1-2016
660-038-0010	1-1-2016	Adopt	2-1-2016
660-038-0020	1-1-2016	Adopt	2-1-2016
660-038-0030	1-1-2016	Adopt	2-1-2016
660-038-0040	1-1-2016	Adopt	2-1-2016
660-038-0050	1-1-2016	Adopt	2-1-2016
660-038-0060	1-1-2016	Adopt	2-1-2016
660-038-0070	1-1-2016	Adopt	2-1-2016
660-038-0080	1-1-2016	Adopt	2-1-2016
660-038-0090	1-1-2016	Adopt	2-1-2016
660-038-0100	1-1-2016	Adopt	2-1-2016
660-038-0110	1-1-2016	Adopt	2-1-2016
660-038-0120	1-1-2016	Adopt	2-1-2016
660-038-0130	1-1-2016	Adopt	2-1-2016
660-038-0140	1-1-2016	Adopt	2-1-2016
660-038-0150	1-1-2016	Adopt	2-1-2016
660-038-0160	1-1-2016	Adopt	2-1-2016
660-038-0170	1-1-2016	Adopt	2-1-2016
660-038-0180	1-1-2016	Adopt	2-1-2016
660-038-0190	1-1-2016	Adopt	2-1-2016
660-038-0200	1-1-2016	Adopt	2-1-2016
668-010-0010	3-9-2016	Amend	4-1-2016
690-051-0000	1-1-2016	Amend	2-1-2016
690-051-0010	1-1-2016	Amend	2-1-2016
690-051-0020	1-1-2016	Amend	2-1-2016
690-051-0030	1-1-2016	Amend	2-1-2016
690-051-0050	1-1-2016	Amend	2-1-2016
690-051-0060	1-1-2016	Amend	2-1-2016
690-051-0090	1-1-2016	Amend	2-1-2016
690-051-0095	1-1-2016	Amend	2-1-2016
690-051-0130	1-1-2016	Amend	2-1-2016
690-051-0140	1-1-2016	Amend	2-1-2016
690-051-0150	1-1-2016	Amend	2-1-2016
690-051-0160	1-1-2016	Amend	2-1-2016
690-051-0170	1-1-2016	Amend	2-1-2016
690-051-0180	1-1-2016	Amend	2-1-2016
690-051-0190	1-1-2016	Amend	2-1-2016
690-051-0200	1-1-2016	Amend	2-1-2016
690-051-0210	1-1-2016	Amend	2-1-2016
690-051-0220	1-1-2016	Amend	2-1-2016
690-051-0230	1-1-2016	Amend	2-1-2016
690-051-0240	1-1-2016	Amend	2-1-2016
690-051-0250	1-1-2016	Amend	2-1-2016
690-051-0270	1-1-2016	Repeal	2-1-2016
690-051-0280	1-1-2016	Amend	2-1-2016
690-051-0290	1-1-2016	Amend	2-1-2016
690-051-0310	1-1-2016	Repeal	2-1-2016
690-051-0320	1-1-2016	Amend	2-1-2016
690-051-0330	1-1-2016	Repeal	2-1-2016
690-051-0340	1-1-2016	Repeal	2-1-2016
690-051-0350	1-1-2016	Amend	2-1-2016
690-051-0360	1-1-2016	Repeal	2-1-2016
690-051-0370	1-1-2016	Repeal	2-1-2016
690-051-0380	1-1-2016	Amend	2-1-2016
690-051-0400	1-1-2016	Amend	2-1-2016
690-079-0010	12-2-2015	Amend(T)	1-1-2016
690-079-0010	4-19-2016	Amend	6-1-2016
690-079-0160	12-2-2015	Adopt(T)	1-1-2016
690-079-0160	4-19-2016	Amend	6-1-2016
690-079-0170	4-19-2016	Adopt	6-1-2016
690-509-0000	3-1-2016	Amend	4-1-2016
690-509-0100	3-1-2016	Amend	4-1-2016
690-512-0010	4-15-2016	Adopt	5-1-2016
690-512-0020	4-15-2016	Adopt	5-1-2016
690-512-0040	4-15-2016	Repeal	5-1-2016
690-512-0090	4-15-2016	Adopt	5-1-2016
710-015-0000	6-20-2016	Adopt	8-1-2016
715-013-0005	12-14-2015	Amend(T)	1-1-2016
715-013-0005	2-19-2016	Amend	4-1-2016
715-013-0005(T)	2-19-2016	Repeal	4-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
715-015-0005	6-14-2016	Adopt	7-1-2016
715-045-0001	3-9-2016	Amend	4-1-2016
715-045-0007	3-9-2016	Amend	4-1-2016
715-045-0012	3-9-2016	Amend	4-1-2016
731-007-0500	4-29-2016	Adopt	6-1-2016
731-007-0510	4-29-2016	Adopt	6-1-2016
731-007-0520	4-29-2016	Adopt	6-1-2016
731-007-0530	4-29-2016	Adopt	6-1-2016
731-007-0540	4-29-2016	Adopt	6-1-2016
731-007-0550	4-29-2016	Adopt	6-1-2016
731-007-0560	4-29-2016	Adopt	6-1-2016
731-007-0570	4-29-2016	Adopt	6-1-2016
731-035-0010	12-17-2015	Amend	2-1-2016
731-035-0020	12-17-2015	Amend	2-1-2016
731-035-0030	12-17-2015	Amend	2-1-2016
731-035-0040	12-17-2015	Amend	2-1-2016
731-035-0050	12-17-2015	Amend	2-1-2016
731-035-0060	12-17-2015	Amend	2-1-2016
731-035-0070	12-17-2015	Amend	2-1-2016
731-035-0080	12-17-2015	Amend	2-1-2016
731-070-0010	3-22-2016	Amend	5-1-2016
731-070-0020	3-22-2016	Amend	5-1-2016
731-070-0030	3-22-2016	Repeal	5-1-2016
731-070-0050	3-22-2016	Amend	5-1-2016
731-070-0055	3-22-2016	Amend	5-1-2016
731-070-0060	3-22-2016	Amend	5-1-2016
731-070-0080	3-22-2016	Amend	5-1-2016
731-070-0110	3-22-2016	Amend	5-1-2016
731-070-0130	3-22-2016	Amend	5-1-2016
731-070-0140	3-22-2016	Amend	5-1-2016
731-070-0160	3-22-2016	Amend	5-1-2016
731-070-0170	3-22-2016	Amend	5-1-2016
731-070-0190	3-22-2016	Repeal	5-1-2016
731-070-0195	3-22-2016	Repeal	5-1-2016
731-070-0240	3-22-2016	Am. & Ren.	5-1-2016
731-070-0245	3-22-2016	Am. & Ren.	5-1-2016
731-070-0250	3-22-2016	Am. & Ren.	5-1-2016
731-070-0260	3-22-2016	Am. & Ren.	5-1-2016
731-070-0350	3-22-2016	Amend	5-1-2016
731-070-0360	3-22-2016	Repeal	5-1-2016
734-010-0200	4-29-2016	Repeal	6-1-2016
734-010-0210	4-29-2016	Repeal	6-1-2016
734-010-0220	4-29-2016	Repeal	6-1-2016
734-010-0230	4-29-2016	Repeal	6-1-2016
734-010-0240	4-29-2016	Repeal	6-1-2016
734-010-0250	4-29-2016	Repeal	6-1-2016
734-010-0260	4-29-2016	Repeal	6-1-2016
734-010-0270	4-29-2016	Repeal	6-1-2016
734-010-0280	4-29-2016	Repeal	6-1-2016
734-020-0018	11-20-2015	Amend	1-1-2016
734-020-0019	11-20-2015	Amend	1-1-2016
734-031-0001	6-21-2016	Adopt	8-1-2016
734-031-0005	6-21-2016	Adopt	8-1-2016
734-031-0010	6-21-2016	Adopt	8-1-2016
734-031-0015	6-21-2016	Adopt	8-1-2016
734-031-0020	6-21-2016	Adopt	8-1-2016
734-031-0025	6-21-2016	Adopt	8-1-2016
734-031-0030	6-21-2016	Adopt	8-1-2016
734-074-0027	12-17-2015	Amend	2-1-2016
734-082-0005	12-17-2015	Amend	2-1-2016
734-082-0040	12-17-2015	Amend	2-1-2016
734-082-0045	12-17-2015	Amend	2-1-2016
734-082-0070	12-17-2015	Amend	2-1-2016
735-032-0070	1-1-2016	Adopt	1-1-2016
735-040-0040	7-1-2016	Amend	8-1-2016
735-040-0045	7-1-2016	Adopt	8-1-2016
735-040-0055	7-1-2016	Repeal	8-1-2016
735-040-0061	7-1-2016	Repeal	8-1-2016
735-040-0095	7-1-2016	Repeal	8-1-2016
735-040-0097	7-1-2016	Repeal	8-1-2016
735-040-0100	7-1-2016	Repeal	8-1-2016
735-040-0110	7-1-2016	Adopt	8-1-2016
735-040-0115	7-1-2016	Adopt	8-1-2016
735-040-0120	7-1-2016	Adopt	8-1-2016
735-040-0125	7-1-2016	Adopt	8-1-2016
735-040-0130	7-1-2016	Adopt	8-1-2016
735-061-0210	4-29-2016	Amend	6-1-2016
735-062-0005	1-1-2016	Amend	2-1-2016
735-062-0007	4-29-2016	Amend	6-1-2016
735-062-0035	1-1-2016	Amend	2-1-2016
735-062-0110	1-1-2016	Amend	2-1-2016
735-062-0120	1-1-2016	Amend	2-1-2016
735-064-0070	1-1-2016	Amend	2-1-2016
735-070-0080	1-1-2016	Amend	2-1-2016
735-070-0082	1-1-2016	Amend	2-1-2016
735-118-0000	1-1-2016	Amend	2-1-2016
735-118-0050	1-1-2016	Amend	2-1-2016
735-150-0010	1-1-2016	Amend	2-1-2016
735-150-0015	1-1-2016	Amend	2-1-2016
735-150-0017	1-1-2016	Amend	2-1-2016
735-150-0020	1-1-2016	Amend	2-1-2016
735-150-0037	1-1-2016	Amend	2-1-2016
735-150-0047	1-1-2016	Amend	2-1-2016
735-150-0055	1-1-2016	Amend	1-1-2016
735-150-0110	1-1-2016	Amend	2-1-2016
735-150-0110	1-1-2016	Amend	2-1-2016
735-150-0140	1-1-2016	Amend	1-1-2016
736-009-0025	5-2-2016	Amend	6-1-2016
736-009-0030	5-2-2016	Amend	6-1-2016
736-015-0010	7-13-2016	Amend	8-1-2016
736-015-0015	7-13-2016	Amend	8-1-2016
736-015-0026	7-13-2016	Amend	8-1-2016
736-015-0035	3-16-2016	Amend	5-1-2016
736-015-0035	7-13-2016	Amend	8-1-2016
738-001-0035	12-15-2015	Amend	1-1-2016
738-010-0025	12-15-2015	Amend	1-1-2016
738-010-0035	12-15-2015	Amend	1-1-2016
738-010-0040	12-15-2015	Repeal	1-1-2016
738-010-0050	12-15-2015	Amend	1-1-2016
738-010-0060	12-15-2015	Amend	1-1-2016
738-080-0010	12-15-2015	Amend	1-1-2016
738-080-0015	12-15-2015	Adopt	1-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
738-080-0020	12-15-2015	Amend	1-1-2016
738-080-0030	12-15-2015	Amend	1-1-2016
738-080-0040	12-15-2015	Repeal	1-1-2016
738-080-0045	12-15-2015	Adopt	1-1-2016
738-124-0010	5-11-2016	Adopt(T)	6-1-2016
738-124-0015	5-11-2016	Adopt(T)	6-1-2016
738-124-0020	5-11-2016	Adopt(T)	6-1-2016
738-124-0025	5-11-2016	Adopt(T)	6-1-2016
738-124-0030	5-11-2016	Adopt(T)	6-1-2016
738-124-0035	5-11-2016	Adopt(T)	6-1-2016
738-124-0040	5-11-2016	Adopt(T)	6-1-2016
738-124-0045	5-11-2016	Adopt(T)	6-1-2016
738-125-0010	5-26-2016	Amend	7-1-2016
738-125-0015	5-26-2016	Amend	7-1-2016
738-125-0020	5-26-2016	Amend	7-1-2016
738-125-0025	5-26-2016	Amend	7-1-2016
738-125-0030	5-26-2016	Amend	7-1-2016
738-125-0035	5-26-2016	Amend	7-1-2016
738-125-0040	5-26-2016	Amend	7-1-2016
738-125-0045	5-26-2016	Amend	7-1-2016
738-125-0050	5-26-2016	Amend	7-1-2016
738-125-0055	5-26-2016	Amend	7-1-2016
738-140-0005	12-15-2015	Adopt	1-1-2016
738-140-0010	12-15-2015	Adopt	1-1-2016
738-140-0015	12-15-2015	Adopt	1-1-2016
738-140-0020	12-15-2015	Adopt	1-1-2016
738-140-0025	12-15-2015	Adopt	1-1-2016
738-140-0030	12-15-2015	Adopt	1-1-2016
738-140-0035	12-15-2015	Adopt	1-1-2016
738-140-0040	12-15-2015	Adopt	1-1-2016
741-520-0010	11-17-2015	Repeal	1-1-2016
800-020-0025	4-1-2016	Amend	5-1-2016
801-001-0035	1-1-2016	Amend(T)	2-1-2016
801-001-0035	6-28-2016	Amend	8-1-2016
804-025-0000	5-25-2016	Amend	7-1-2016
804-025-0010	5-25-2016	Amend	7-1-2016
804-025-0015	5-25-2016	Amend	7-1-2016
804-025-0020	5-25-2016	Amend	7-1-2016
804-025-0030	5-25-2016	Amend	7-1-2016
804-025-0035	5-25-2016	Amend	7-1-2016
806-010-0010	12-14-2015	Amend	1-1-2016
806-010-0020	12-14-2015	Amend	1-1-2016
806-010-0035	12-14-2015	Amend	1-1-2016
808-001-0005	5-23-2016	Amend	7-1-2016
808-002-0020	1-1-2016	Amend	2-1-2016
808-002-0200	1-1-2016	Amend	2-1-2016
808-002-0200	5-23-2016	Amend	7-1-2016
808-002-0250	1-1-2016	Repeal	2-1-2016
808-002-0300	1-1-2016	Amend	2-1-2016
808-002-0320	1-1-2016	Amend	2-1-2016
808-002-0338	1-1-2016	Amend	2-1-2016
808-002-0455	1-1-2016	Amend	2-1-2016
808-002-0480	1-1-2016	Amend	2-1-2016
808-002-0480	5-23-2016	Amend	7-1-2016
808-002-0490	1-1-2016	Amend	2-1-2016
808-002-0500	1-1-2016	Amend	2-1-2016
808-002-0620	5-23-2016	Amend	7-1-2016
808-002-0730	1-1-2016	Amend	2-1-2016
808-002-0780	1-1-2016	Amend	2-1-2016
808-002-0810	1-1-2016	Repeal	2-1-2016
808-002-0884	1-1-2016	Repeal	2-1-2016
808-002-0920	1-1-2016	Amend	2-1-2016
808-003-0015	1-1-2016	Amend	2-1-2016
808-003-0018	1-1-2016	Amend	2-1-2016
808-003-0025	5-23-2016	Amend	7-1-2016
808-003-0030	5-23-2016	Amend	7-1-2016
808-003-0040	1-1-2016	Amend	2-1-2016
808-003-0045	5-23-2016	Amend	7-1-2016
808-003-0055	5-23-2016	Repeal	7-1-2016
808-003-0060	1-1-2016	Amend	2-1-2016
808-003-0060	5-23-2016	Repeal	7-1-2016
808-003-0065	5-23-2016	Repeal	7-1-2016
808-003-0075	5-23-2016	Repeal	7-1-2016
808-003-0080	5-23-2016	Repeal	7-1-2016
808-003-0081	5-23-2016	Repeal	7-1-2016
808-003-0085	5-23-2016	Repeal	7-1-2016
808-003-0095	1-1-2016	Amend	2-1-2016
808-003-0125	1-1-2016	Amend	2-1-2016
808-003-0126	1-1-2016	Amend	2-1-2016
808-003-0130	5-23-2016	Amend	7-1-2016
808-003-0230	1-1-2016	Amend	2-1-2016
808-003-0230	5-23-2016	Amend	7-1-2016
808-003-0234	5-23-2016	Adopt	7-1-2016
808-003-0610	1-1-2016	Amend	2-1-2016
808-003-0610(T)	1-1-2016	Repeal	2-1-2016
808-003-0611	1-1-2016	Amend	2-1-2016
808-003-0613	1-1-2016	Amend	2-1-2016
808-003-0700	5-23-2016	Adopt	7-1-2016
808-003-0710	5-23-2016	Adopt	7-1-2016
808-003-0720	5-23-2016	Adopt	7-1-2016
808-003-0730	5-23-2016	Adopt	7-1-2016
808-003-0740	5-23-2016	Adopt	7-1-2016
808-003-0750	5-23-2016	Adopt	7-1-2016
808-003-0800	5-23-2016	Adopt	7-1-2016
808-003-0810	5-23-2016	Adopt	7-1-2016
808-003-0820	5-23-2016	Adopt	7-1-2016
808-003-0830	5-23-2016	Adopt	7-1-2016
808-003-0840	5-23-2016	Adopt	7-1-2016
808-003-0850	5-23-2016	Adopt	7-1-2016
808-003-0900	5-23-2016	Adopt	7-1-2016
808-003-0910	5-23-2016	Adopt	7-1-2016
808-003-0920	5-23-2016	Adopt	7-1-2016
808-003-0930	5-23-2016	Adopt	7-1-2016
808-003-0940	5-23-2016	Adopt	7-1-2016
808-003-0950	5-23-2016	Adopt	7-1-2016
808-003-0960	5-23-2016	Adopt	7-1-2016
808-003-0970	5-23-2016	Adopt	7-1-2016
808-003-0980	5-23-2016	Adopt	7-1-2016
808-003-0985	5-23-2016	Adopt	7-1-2016
808-003-0990	5-23-2016	Adopt	7-1-2016
808-003-0995	5-23-2016	Adopt	7-1-2016
808-004-0160	5-23-2016	Amend	7-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
808-004-0180	1-1-2016	Amend	2-1-2016
808-004-0180	5-23-2016	Repeal	7-1-2016
808-004-0211	1-1-2016	Amend	2-1-2016
808-004-0211	5-23-2016	Amend	7-1-2016
808-004-0240	5-23-2016	Repeal	7-1-2016
808-004-0250	5-23-2016	Amend	7-1-2016
808-004-0260	5-23-2016	Amend	7-1-2016
808-004-0310	5-23-2016	Amend	7-1-2016
808-004-0320	1-1-2016	Amend	2-1-2016
808-004-0320	5-23-2016	Amend	7-1-2016
808-004-0350	5-23-2016	Amend	7-1-2016
808-004-0400	5-23-2016	Amend	7-1-2016
808-004-0440	5-23-2016	Amend	7-1-2016
808-004-0450	5-23-2016	Amend	7-1-2016
808-004-0460	5-23-2016	Repeal	7-1-2016
808-004-0470	5-23-2016	Repeal	7-1-2016
808-004-0480	5-23-2016	Amend	7-1-2016
808-004-0500	5-23-2016	Amend	7-1-2016
808-004-0510	5-23-2016	Amend	7-1-2016
808-004-0520	5-23-2016	Amend	7-1-2016
808-004-0530	5-23-2016	Amend	7-1-2016
808-004-0540	5-23-2016	Amend	7-1-2016
808-004-0550	5-23-2016	Repeal	7-1-2016
808-004-0560	5-23-2016	Repeal	7-1-2016
808-004-0590	5-23-2016	Amend	7-1-2016
808-030-0020	5-23-2016	Amend	7-1-2016
808-030-0040	5-23-2016	Amend	7-1-2016
808-040-0020	1-1-2016	Amend	2-1-2016
808-040-0020	5-23-2016	Amend	7-1-2016
808-040-0025	4-8-2016	Amend	5-1-2016
808-040-0050	4-8-2016	Amend	5-1-2016
808-040-0060	4-8-2016	Amend	5-1-2016
808-040-0070	5-23-2016	Amend	7-1-2016
808-040-0080	1-1-2016	Amend	2-1-2016
808-040-0080	5-23-2016	Amend	7-1-2016
811-010-0084	6-6-2016	Amend	7-1-2016
811-010-0085	5-2-2016	Amend	5-1-2016
811-010-0110	6-6-2016	Amend	7-1-2016
812-006-0100	7-1-2016	Amend	7-1-2016
812-006-0150	7-1-2016	Amend	7-1-2016
812-006-0160	7-1-2016	Adopt	7-1-2016
812-006-0200	7-1-2016	Amend	7-1-2016
812-006-0310	7-1-2016	Adopt	7-1-2016
812-006-0400	7-1-2016	Amend	7-1-2016
812-008-0020	7-1-2016	Amend	7-1-2016
812-008-0072	7-1-2016	Amend	7-1-2016
812-008-0074	7-1-2016	Amend	7-1-2016
812-020-0050	7-1-2016	Amend	7-1-2016
812-020-0062	7-1-2016	Amend	7-1-2016
812-020-0070	7-1-2016	Amend	7-1-2016
812-020-0071	7-1-2016	Amend	7-1-2016
812-020-0080	7-1-2016	Repeal	7-1-2016
812-021-0000	7-1-2016	Repeal	7-1-2016
812-021-0005	7-1-2016	Repeal	7-1-2016
812-021-0010	7-1-2016	Repeal	7-1-2016
812-021-0011	7-1-2016	Repeal	7-1-2016
812-021-0015	7-1-2016	Repeal	7-1-2016
812-021-0016	7-1-2016	Repeal	7-1-2016
812-021-0019	7-1-2016	Repeal	7-1-2016
812-021-0021	7-1-2016	Repeal	7-1-2016
812-021-0023	7-1-2016	Repeal	7-1-2016
812-021-0025	7-1-2016	Repeal	7-1-2016
812-021-0028	7-1-2016	Repeal	7-1-2016
812-021-0030	7-1-2016	Repeal	7-1-2016
812-021-0031	7-1-2016	Repeal	7-1-2016
812-021-0032	7-1-2016	Repeal	7-1-2016
812-021-0033	7-1-2016	Repeal	7-1-2016
812-021-0034	7-1-2016	Repeal	7-1-2016
812-021-0035	7-1-2016	Repeal	7-1-2016
812-021-0037	7-1-2016	Repeal	7-1-2016
812-021-0040	7-1-2016	Repeal	7-1-2016
812-021-0042	7-1-2016	Repeal	7-1-2016
812-021-0045	7-1-2016	Repeal	7-1-2016
812-021-0047	7-1-2016	Repeal	7-1-2016
812-022-0010	7-1-2016	Amend	7-1-2016
812-022-0011	7-1-2016	Repeal	7-1-2016
812-022-0021	7-1-2016	Amend	7-1-2016
813-005-0005	6-29-2016	Amend(T)	8-1-2016
813-005-0025	6-29-2016	Adopt(T)	8-1-2016
813-006-0005	6-29-2016	Amend(T)	8-1-2016
813-006-0010	6-29-2016	Amend(T)	8-1-2016
813-013-0001	11-30-2015	Amend(T)	1-1-2016
813-013-0001	5-27-2016	Amend	7-1-2016
813-013-0005	11-30-2015	Amend(T)	1-1-2016
813-013-0005	5-27-2016	Amend	7-1-2016
813-013-0010	11-30-2015	Amend(T)	1-1-2016
813-013-0010	5-27-2016	Amend	7-1-2016
813-013-0015	11-30-2015	Amend(T)	1-1-2016
813-013-0015	5-27-2016	Amend	7-1-2016
813-013-0020	11-30-2015	Amend(T)	1-1-2016
813-013-0020	5-27-2016	Amend	7-1-2016
813-013-0035	11-30-2015	Amend(T)	1-1-2016
813-013-0035	5-27-2016	Amend	7-1-2016
813-013-0040	11-30-2015	Amend(T)	1-1-2016
813-013-0040	5-27-2016	Amend	7-1-2016
813-013-0050	11-30-2015	Amend(T)	1-1-2016
813-013-0050	5-27-2016	Amend	7-1-2016
813-013-0054	11-30-2015	Amend(T)	1-1-2016
813-013-0054	5-27-2016	Amend	7-1-2016
813-110-0010	5-5-2016	Amend(T)	6-1-2016
813-110-0013	5-5-2016	Amend(T)	6-1-2016
813-110-0015	5-5-2016	Amend(T)	6-1-2016
813-300-0005	3-25-2016	Amend	5-1-2016
813-300-0120	3-25-2016	Amend	5-1-2016
813-300-0150	3-25-2016	Amend	5-1-2016
813-300-0150	4-20-2016	Amend(T)	6-1-2016
813-300-0150(T)	3-25-2016	Repeal	5-1-2016
813-330-0000	2-11-2016	Adopt	3-1-2016
813-330-0010	2-11-2016	Adopt	3-1-2016
813-330-0020	2-11-2016	Adopt	3-1-2016
813-330-0030	2-11-2016	Adopt	3-1-2016
813-330-0040	2-11-2016	Adopt	3-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
813-330-0050	2-11-2016	Adopt	3-1-2016
813-330-0060	2-11-2016	Adopt	3-1-2016
817-090-0025	4-4-2016	Amend	5-1-2016
817-090-0035	4-4-2016	Amend	5-1-2016
817-090-0050	4-4-2016	Repeal	5-1-2016
817-090-0080	4-4-2016	Amend	5-1-2016
817-090-0090	4-4-2016	Amend	5-1-2016
817-090-0100	4-4-2016	Amend	5-1-2016
819-005-0000	7-1-2016	Adopt(T)	8-1-2016
819-020-0030	7-1-2016	Adopt(T)	8-1-2016
819-020-0040	7-1-2016	Adopt(T)	8-1-2016
819-020-0050	7-1-2016	Adopt(T)	8-1-2016
819-020-0060	7-1-2016	Adopt(T)	8-1-2016
819-020-0070	7-1-2016	Adopt(T)	8-1-2016
819-020-0080	7-1-2016	Adopt(T)	8-1-2016
819-040-0000	7-1-2016	Adopt(T)	8-1-2016
820-010-0505	2-16-2016	Amend	4-1-2016
820-010-0615	5-12-2016	Amend	6-1-2016
820-010-3020	1-14-2016	Adopt	2-1-2016
820-010-4000	3-15-2016	Amend(T)	4-1-2016
820-010-5000	1-15-2016	Amend(T)	2-1-2016
820-010-5000	5-12-2016	Amend	6-1-2016
820-010-5000(T)	5-12-2016	Repeal	6-1-2016
820-015-0026	2-16-2016	Amend	4-1-2016
820-020-0015	2-16-2016	Amend	4-1-2016
820-020-0025	2-16-2016	Amend	4-1-2016
820-020-0030	2-16-2016	Amend	4-1-2016
820-020-0035	2-16-2016	Amend	4-1-2016
820-020-0040	1-14-2016	Amend	2-1-2016
820-025-0005	5-12-2016	Amend	6-1-2016
820-025-0015	1-15-2016	Amend(T)	2-1-2016
820-025-0015	5-12-2016	Amend	6-1-2016
820-025-0015(T)	5-12-2016	Repeal	6-1-2016
820-030-0005	2-16-2016	Adopt	4-1-2016
820-040-0005	2-16-2016	Amend	4-1-2016
830-011-0000	1-1-2016	Amend	2-1-2016
830-011-0020	1-1-2016	Amend	2-1-2016
830-011-0040	1-1-2016	Amend	2-1-2016
830-011-0065	1-1-2016	Adopt	2-1-2016
830-011-0065	7-6-2016	Amend(T)	8-1-2016
830-020-0000	1-1-2016	Amend	2-1-2016
830-020-0030	1-1-2016	Amend	2-1-2016
830-020-0040	1-1-2016	Amend	2-1-2016
830-030-0004	1-1-2016	Amend	2-1-2016
830-030-0090	1-1-2016	Amend	2-1-2016
830-040-0095	1-1-2016	Adopt	2-1-2016
833-020-0101	6-7-2016	Amend	7-1-2016
833-120-0011	4-1-2016	Amend	5-1-2016
834-020-0000	3-1-2016	Amend	4-1-2016
834-030-0000	3-1-2016	Amend	4-1-2016
834-030-0010	3-1-2016	Amend	4-1-2016
834-040-0000	3-1-2016	Amend	4-1-2016
834-050-0000	3-1-2016	Amend	4-1-2016
834-050-0010	3-1-2016	Amend	4-1-2016
836-009-0020	4-8-2016	Repeal	5-1-2016
836-009-0025	4-8-2016	Repeal	5-1-2016
836-009-0030	4-8-2016	Repeal	5-1-2016
836-009-0035	4-8-2016	Repeal	5-1-2016
836-009-0040	4-8-2016	Repeal	5-1-2016
836-010-0013	4-8-2016	Amend	5-1-2016
836-010-0013	4-28-2016	Amend(T)	6-1-2016
836-010-0155	4-26-2016	Adopt	6-1-2016
836-011-0000	2-3-2016	Amend	3-1-2016
836-027-0005	3-3-2016	Amend	4-1-2016
836-027-0010	3-3-2016	Amend	4-1-2016
836-027-0012	3-3-2016	Amend	4-1-2016
836-027-0100	3-3-2016	Amend	4-1-2016
836-027-0125	3-3-2016	Amend	4-1-2016
836-027-0140	3-3-2016	Amend	4-1-2016
836-027-0160	3-3-2016	Amend	4-1-2016
836-051-0150	1-1-2016	Adopt	2-1-2016
836-051-0153	1-1-2016	Adopt	2-1-2016
836-051-0156	1-1-2016	Adopt	2-1-2016
836-052-0142	1-1-2016	Amend	2-1-2016
836-052-0536	7-6-2016	Repeal	8-1-2016
836-052-0740	7-6-2016	Amend	8-1-2016
836-052-1000	4-8-2016	Amend	5-1-2016
836-053-0002	12-17-2015	Amend(T)	2-1-2016
836-053-0002	4-26-2016	Amend	6-1-2016
836-053-0004	12-17-2015	Adopt(T)	2-1-2016
836-053-0004	4-26-2016	Adopt	6-1-2016
836-053-0004(T)	4-26-2016	Repeal	6-1-2016
836-053-0008	12-17-2015	Amend(T)	2-1-2016
836-053-0008	4-26-2016	Amend	6-1-2016
836-053-0009	12-17-2015	Amend(T)	2-1-2016
836-053-0009	4-26-2016	Amend	6-1-2016
836-053-0010	4-8-2016	Amend	5-1-2016
836-053-0010	4-26-2016	Am. & Ren.	6-1-2016
836-053-0012	12-17-2015	Adopt(T)	2-1-2016
836-053-0012	4-26-2016	Adopt	6-1-2016
836-053-0012(T)	4-26-2016	Repeal	6-1-2016
836-053-0013	12-17-2015	Adopt(T)	2-1-2016
836-053-0013	4-26-2016	Adopt	6-1-2016
836-053-0013(T)	4-26-2016	Repeal	6-1-2016
836-053-0014(T)	4-8-2016	Repeal	5-1-2016
836-053-0015	4-8-2016	Adopt	5-1-2016
836-053-0015(T)	4-8-2016	Repeal	5-1-2016
836-053-0021	4-8-2016	Amend	5-1-2016
836-053-0030	4-8-2016	Amend	5-1-2016
836-053-0050	4-8-2016	Amend	5-1-2016
836-053-0066	4-8-2016	Amend	5-1-2016
836-053-0230	4-8-2016	Amend	5-1-2016
836-053-0410	4-8-2016	Amend	5-1-2016
836-053-0431	4-8-2016	Amend	5-1-2016
836-053-0465	4-8-2016	Amend	5-1-2016
836-053-0472	4-8-2016	Amend	5-1-2016
836-053-0510	4-8-2016	Amend	5-1-2016
836-053-0600	1-1-2016	Adopt	2-1-2016
836-053-0600(T)	1-1-2016	Repeal	2-1-2016
836-053-0605	1-1-2016	Adopt	2-1-2016
836-053-0605(T)	1-1-2016	Repeal	2-1-2016
836-053-0610	1-1-2016	Adopt	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
836-053-0610(T)	1-1-2016	Repeal	2-1-2016
836-053-0615	1-1-2016	Adopt	2-1-2016
836-053-0615(T)	1-1-2016	Repeal	2-1-2016
836-053-0825	4-8-2016	Amend	5-1-2016
836-053-0830	4-8-2016	Amend	5-1-2016
836-053-0835	4-8-2016	Amend	5-1-2016
836-053-1020	12-17-2015	Amend(T)	2-1-2016
836-053-1020	4-26-2016	Amend	6-1-2016
836-053-1404	12-17-2015	Amend(T)	2-1-2016
836-053-1404	4-26-2016	Amend	6-1-2016
836-053-1405	12-17-2015	Amend(T)	2-1-2016
836-053-1405	4-26-2016	Amend	6-1-2016
836-053-1406	4-26-2016	Am. & Ren.	6-1-2016
836-053-1500	4-8-2016	Adopt	5-1-2016
836-053-1500(T)	4-8-2016	Repeal	5-1-2016
836-053-1505	4-8-2016	Adopt	5-1-2016
836-053-1505(T)	4-8-2016	Repeal	5-1-2016
836-053-1510	4-8-2016	Adopt	5-1-2016
836-053-1510(T)	4-8-2016	Repeal	5-1-2016
836-054-0000	1-1-2016	Amend	2-1-2016
836-054-0000(T)	1-1-2016	Repeal	2-1-2016
836-054-0020	1-1-2016	Adopt	2-1-2016
836-071-0108	7-1-2016	Amend	8-1-2016
836-071-0354	1-1-2016	Adopt	2-1-2016
836-071-0354	1-20-2016	Adopt	3-1-2016
836-071-0355	1-1-2016	Amend	2-1-2016
836-071-0355	1-20-2016	Amend	3-1-2016
836-071-0370	1-1-2016	Amend	2-1-2016
836-071-0370	1-20-2016	Amend	3-1-2016
836-071-0380	1-1-2016	Amend	2-1-2016
836-071-0380	1-20-2016	Amend	3-1-2016
836-071-0450	7-1-2016	Adopt	8-1-2016
837-012-0305	1-1-2016	Amend	2-1-2016
837-012-0310	1-1-2016	Amend	2-1-2016
837-012-0315	1-1-2016	Amend	2-1-2016
837-012-0320	1-1-2016	Amend	2-1-2016
837-012-0325	1-1-2016	Amend	2-1-2016
837-012-0330	1-1-2016	Amend	2-1-2016
837-012-0340	1-1-2016	Amend	2-1-2016
837-012-0350	1-1-2016	Amend	2-1-2016
837-012-0360	1-1-2016	Amend	2-1-2016
837-012-0370	1-1-2016	Amend	2-1-2016
837-012-0500	1-1-2016	Amend	2-1-2016
837-012-0510	1-1-2016	Amend	2-1-2016
837-012-0515	1-1-2016	Amend	2-1-2016
837-012-0520	1-1-2016	Amend	2-1-2016
837-012-0525	1-1-2016	Amend	2-1-2016
837-012-0530	1-1-2016	Amend	2-1-2016
837-012-0535	1-1-2016	Amend	2-1-2016
837-012-0540	1-1-2016	Amend	2-1-2016
837-012-0545	1-1-2016	Amend	2-1-2016
837-012-0550	1-1-2016	Amend	2-1-2016
837-012-0555	1-1-2016	Amend	2-1-2016
837-012-0560	1-1-2016	Amend	2-1-2016
837-012-0565	1-1-2016	Amend	2-1-2016
837-012-0570	1-1-2016	Amend	2-1-2016
837-012-0600	1-1-2016	Amend	2-1-2016
837-012-0610	1-1-2016	Amend	2-1-2016
837-012-0615	1-1-2016	Amend	2-1-2016
837-012-0620	1-1-2016	Amend	2-1-2016
837-012-0625	1-1-2016	Amend	2-1-2016
837-012-0630	1-1-2016	Amend	2-1-2016
837-012-0635	1-1-2016	Amend	2-1-2016
837-012-0640	1-1-2016	Amend	2-1-2016
837-012-0645	1-1-2016	Amend	2-1-2016
837-012-0650	1-1-2016	Amend	2-1-2016
837-012-0655	1-1-2016	Amend	2-1-2016
837-012-0660	1-1-2016	Amend	2-1-2016
837-012-0665	1-1-2016	Amend	2-1-2016
837-012-0670	1-1-2016	Amend	2-1-2016
837-012-0675	1-1-2016	Amend	2-1-2016
837-012-0700	1-1-2016	Amend	2-1-2016
837-012-0710	1-1-2016	Amend	2-1-2016
837-012-0720	1-1-2016	Amend	2-1-2016
837-012-0730	1-1-2016	Amend	2-1-2016
837-012-0740	1-1-2016	Amend	2-1-2016
837-012-0750	1-1-2016	Amend	2-1-2016
837-012-0760	1-1-2016	Amend	2-1-2016
837-012-0770	1-1-2016	Amend	2-1-2016
837-012-0780	1-1-2016	Amend	2-1-2016
837-012-0790	1-1-2016	Amend	2-1-2016
837-012-0800	1-1-2016	Amend	2-1-2016
837-012-0810	1-1-2016	Amend	2-1-2016
837-012-0820	1-1-2016	Amend	2-1-2016
837-012-0830	1-1-2016	Amend	2-1-2016
837-012-0835	1-1-2016	Amend	2-1-2016
837-012-0840	1-1-2016	Amend	2-1-2016
837-012-0850	1-1-2016	Amend	2-1-2016
837-012-0855	1-1-2016	Amend	2-1-2016
837-012-0860	1-1-2016	Amend	2-1-2016
837-012-0865	1-1-2016	Amend	2-1-2016
837-012-0870	1-1-2016	Amend	2-1-2016
837-012-0875	1-1-2016	Amend	2-1-2016
837-012-0880	1-1-2016	Amend	2-1-2016
837-012-0890	1-1-2016	Amend	2-1-2016
837-012-0900	1-1-2016	Amend	2-1-2016
837-012-0910	1-1-2016	Amend	2-1-2016
837-012-0920	1-1-2016	Amend	2-1-2016
837-012-0940	1-1-2016	Amend	2-1-2016
837-012-0950	1-1-2016	Amend	2-1-2016
837-012-0960	1-1-2016	Amend	2-1-2016
837-012-0970	1-1-2016	Amend	2-1-2016
837-012-1000	1-1-2016	Amend	2-1-2016
837-012-1010	1-1-2016	Amend	2-1-2016
837-012-1020	1-1-2016	Amend	2-1-2016
837-012-1030	1-1-2016	Amend	2-1-2016
837-012-1040	1-1-2016	Amend	2-1-2016
837-012-1050	1-1-2016	Amend	2-1-2016
837-012-1060	1-1-2016	Amend	2-1-2016
837-012-1070	1-1-2016	Amend	2-1-2016
837-012-1080	1-1-2016	Amend	2-1-2016
837-012-1090	1-1-2016	Amend	2-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
837-012-1100	1-1-2016	Amend	2-1-2016
837-012-1110	1-1-2016	Amend	2-1-2016
837-012-1120	1-1-2016	Amend	2-1-2016
837-012-1130	1-1-2016	Amend	2-1-2016
837-012-1140	1-1-2016	Amend	2-1-2016
837-012-1150	1-1-2016	Amend	2-1-2016
837-012-1160	1-1-2016	Amend	2-1-2016
837-090-1030	7-1-2016	Amend	8-1-2016
839-005-0003	1-1-2016	Amend	2-1-2016
839-005-0400	1-1-2016	Amend	2-1-2016
839-007-0000	1-1-2016	Adopt	1-1-2016
839-007-0005	1-1-2016	Adopt	1-1-2016
839-007-0007	1-1-2016	Adopt	1-1-2016
839-007-0010	1-1-2016	Adopt	1-1-2016
839-007-0012	1-1-2016	Adopt	1-1-2016
839-007-0015	1-1-2016	Adopt	1-1-2016
839-007-0020	1-1-2016	Adopt	1-1-2016
839-007-0025	1-1-2016	Adopt	1-1-2016
839-007-0030	1-1-2016	Adopt	1-1-2016
839-007-0032	1-1-2016	Adopt	1-1-2016
839-007-0035	1-1-2016	Adopt	1-1-2016
839-007-0040	1-1-2016	Adopt	1-1-2016
839-007-0045	1-1-2016	Adopt	1-1-2016
839-007-0050	1-1-2016	Adopt	1-1-2016
839-007-0055	1-1-2016	Adopt	1-1-2016
839-007-0060	1-1-2016	Adopt	1-1-2016
839-007-0065	1-1-2016	Adopt	1-1-2016
839-007-0100	1-1-2016	Adopt	1-1-2016
839-007-0120	1-1-2016	Adopt	1-1-2016
839-009-0270	1-1-2016	Amend	2-1-2016
839-020-0004	7-1-2016	Amend	7-1-2016
839-020-0010	7-1-2016	Amend	7-1-2016
839-020-0011	7-1-2016	Adopt	7-1-2016
839-020-0030	1-1-2016	Amend	2-1-2016
839-020-0042	1-1-2016	Amend	2-1-2016
839-020-0052	1-1-2016	Adopt	2-1-2016
839-020-0125	1-1-2016	Amend	2-1-2016
839-020-1010	1-1-2016	Amend	2-1-2016
839-025-0004	3-31-2016	Amend	5-1-2016
839-025-0020	3-31-2016	Amend	5-1-2016
839-025-0037	3-31-2016	Amend	5-1-2016
839-025-0100	3-31-2016	Amend	5-1-2016
839-025-0320	3-31-2016	Amend	5-1-2016
839-025-0530	3-31-2016	Amend	5-1-2016
839-025-0700	1-1-2016	Amend	1-1-2016
839-025-0700	4-1-2016	Amend	5-1-2016
839-025-0700	7-1-2016	Amend	7-1-2016
845-003-0210	2-23-2016	Amend(T)	4-1-2016
845-003-0220	2-23-2016	Amend(T)	4-1-2016
845-003-0270	2-23-2016	Amend(T)	4-1-2016
845-003-0331	2-23-2016	Amend(T)	4-1-2016
845-004-0015	2-23-2016	Amend(T)	4-1-2016
845-004-0101	2-1-2016	Amend	2-1-2016
845-004-0105	2-1-2016	Repeal	2-1-2016
845-005-0400	3-1-2016	Amend	4-1-2016
845-005-0413	2-1-2016	Amend	2-1-2016
845-005-0417	1-1-2016	Amend(T)	2-1-2016
845-005-0417	6-29-2016	Amend	8-1-2016
845-005-0420	1-1-2016	Suspend	2-1-2016
845-005-0420	6-29-2016	Repeal	8-1-2016
845-005-0428	4-1-2016	Amend	5-1-2016
845-005-0431	2-1-2016	Amend	2-1-2016
845-006-0392	1-1-2016	Amend(T)	2-1-2016
845-006-0392	6-29-2016	Amend	8-1-2016
845-006-0396	1-1-2016	Amend(T)	2-1-2016
845-006-0396	6-29-2016	Amend	8-1-2016
845-006-0446	4-1-2016	Adopt	5-1-2016
845-006-0450	4-1-2016	Amend	5-1-2016
845-006-0452	2-1-2016	Amend	2-1-2016
845-013-0040	4-1-2016	Amend	5-1-2016
845-015-0130	6-29-2016	Repeal	8-1-2016
845-015-0148	5-2-2016	Amend	6-1-2016
845-015-0155	6-29-2016	Amend	8-1-2016
845-015-0175	6-29-2016	Amend	8-1-2016
845-015-0177	6-29-2016	Amend	8-1-2016
845-015-0190	6-29-2016	Amend	8-1-2016
845-025-1000	1-1-2016	Adopt(T)	1-1-2016
845-025-1000	6-29-2016	Adopt	8-1-2016
845-025-1015	1-1-2016	Adopt(T)	1-1-2016
845-025-1015	6-29-2016	Adopt	8-1-2016
845-025-1015	6-30-2016	Amend(T)	8-1-2016
845-025-1030	1-1-2016	Adopt(T)	1-1-2016
845-025-1030	6-29-2016	Adopt	8-1-2016
845-025-1030	6-30-2016	Amend(T)	8-1-2016
845-025-1045	1-1-2016	Adopt(T)	1-1-2016
845-025-1045	6-29-2016	Adopt	8-1-2016
845-025-1045	6-30-2016	Amend(T)	8-1-2016
845-025-1060	1-1-2016	Adopt(T)	1-1-2016
845-025-1060	6-29-2016	Adopt	8-1-2016
845-025-1060	6-30-2016	Amend(T)	8-1-2016
845-025-1070	1-1-2016	Adopt(T)	1-1-2016
845-025-1070	6-29-2016	Adopt	8-1-2016
845-025-1080	1-1-2016	Adopt(T)	1-1-2016
845-025-1080	6-29-2016	Adopt	8-1-2016
845-025-1090	1-1-2016	Adopt(T)	1-1-2016
845-025-1090	6-29-2016	Adopt	8-1-2016
845-025-1090	6-30-2016	Amend(T)	8-1-2016
845-025-1100	1-1-2016	Adopt(T)	1-1-2016
845-025-1100	6-29-2016	Adopt	8-1-2016
845-025-1115	1-1-2016	Adopt(T)	1-1-2016
845-025-1115	1-1-2016	Amend(T)	2-1-2016
845-025-1115	6-29-2016	Adopt	8-1-2016
845-025-1115	6-30-2016	Amend(T)	8-1-2016
845-025-1130	1-1-2016	Adopt(T)	1-1-2016
845-025-1130	6-29-2016	Adopt	8-1-2016
845-025-1145	1-1-2016	Adopt(T)	1-1-2016
845-025-1145	6-29-2016	Adopt	8-1-2016
845-025-1160	1-1-2016	Adopt(T)	1-1-2016
845-025-1160	6-29-2016	Adopt	8-1-2016
845-025-1175	1-1-2016	Adopt(T)	1-1-2016
845-025-1175	6-29-2016	Adopt	8-1-2016
845-025-1190	1-1-2016	Adopt(T)	1-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
845-025-1190	6-29-2016	Adopt	8-1-2016
845-025-1200	1-1-2016	Adopt(T)	1-1-2016
845-025-1200	6-29-2016	Adopt	8-1-2016
845-025-1215	1-1-2016	Adopt(T)	1-1-2016
845-025-1215	6-29-2016	Adopt	8-1-2016
845-025-1230	1-1-2016	Adopt(T)	1-1-2016
845-025-1230	6-29-2016	Adopt	8-1-2016
845-025-1245	1-1-2016	Adopt(T)	1-1-2016
845-025-1245	6-29-2016	Adopt	8-1-2016
845-025-1260	1-1-2016	Adopt(T)	1-1-2016
845-025-1260	6-29-2016	Adopt	8-1-2016
845-025-1275	1-1-2016	Adopt(T)	1-1-2016
845-025-1275	6-29-2016	Adopt	8-1-2016
845-025-1290	1-1-2016	Adopt(T)	1-1-2016
845-025-1290	6-29-2016	Adopt	8-1-2016
845-025-1295	1-1-2016	Adopt(T)	1-1-2016
845-025-1295	6-29-2016	Adopt	8-1-2016
845-025-1300	1-1-2016	Adopt(T)	1-1-2016
845-025-1300	6-29-2016	Adopt	8-1-2016
845-025-1330	6-29-2016	Adopt	8-1-2016
845-025-1360	6-29-2016	Adopt	8-1-2016
845-025-1400	1-1-2016	Adopt(T)	1-1-2016
845-025-1400	6-29-2016	Adopt	8-1-2016
845-025-1405	6-29-2016	Adopt	8-1-2016
845-025-1410	1-1-2016	Adopt(T)	1-1-2016
845-025-1410	6-29-2016	Adopt	8-1-2016
845-025-1420	1-1-2016	Adopt(T)	1-1-2016
845-025-1420	6-29-2016	Adopt	8-1-2016
845-025-1430	1-1-2016	Adopt(T)	1-1-2016
845-025-1430	6-29-2016	Adopt	8-1-2016
845-025-1440	1-1-2016	Adopt(T)	1-1-2016
845-025-1440	6-29-2016	Adopt	8-1-2016
845-025-1450	1-1-2016	Adopt(T)	1-1-2016
845-025-1450	6-29-2016	Adopt	8-1-2016
845-025-1460	1-1-2016	Adopt(T)	1-1-2016
845-025-1460	6-29-2016	Adopt	8-1-2016
845-025-1470	1-1-2016	Adopt(T)	1-1-2016
845-025-1470	6-29-2016	Adopt	8-1-2016
845-025-1600	1-1-2016	Adopt(T)	1-1-2016
845-025-1600	6-29-2016	Adopt	8-1-2016
845-025-1620	1-1-2016	Adopt(T)	1-1-2016
845-025-1620	6-29-2016	Adopt	8-1-2016
845-025-2000	1-1-2016	Adopt(T)	1-1-2016
845-025-2000	6-29-2016	Adopt	8-1-2016
845-025-2020	1-1-2016	Adopt(T)	1-1-2016
845-025-2020	6-29-2016	Adopt	8-1-2016
845-025-2020	6-30-2016	Amend(T)	8-1-2016
845-025-2030	1-1-2016	Adopt(T)	1-1-2016
845-025-2030	6-29-2016	Adopt	8-1-2016
845-025-2030	6-30-2016	Amend(T)	8-1-2016
845-025-2040	1-1-2016	Adopt(T)	1-1-2016
845-025-2040	6-29-2016	Adopt	8-1-2016
845-025-2050	1-1-2016	Adopt(T)	1-1-2016
845-025-2050	6-29-2016	Adopt	8-1-2016
845-025-2060	1-1-2016	Adopt(T)	1-1-2016
845-025-2060	6-29-2016	Adopt	8-1-2016
845-025-2060	6-30-2016	Amend(T)	8-1-2016
845-025-2070	1-1-2016	Adopt(T)	1-1-2016
845-025-2070	6-29-2016	Adopt	8-1-2016
845-025-2080	1-1-2016	Adopt(T)	1-1-2016
845-025-2080	6-29-2016	Adopt	8-1-2016
845-025-2100	6-30-2016	Adopt(T)	8-1-2016
845-025-2400	1-1-2016	Adopt(T)	1-1-2016
845-025-2800	1-1-2016	Adopt(T)	1-1-2016
845-025-2800	6-29-2016	Adopt	8-1-2016
845-025-2800	6-30-2016	Amend(T)	8-1-2016
845-025-2820	1-1-2016	Adopt(T)	1-1-2016
845-025-2820	6-29-2016	Adopt	8-1-2016
845-025-2840	1-1-2016	Adopt(T)	1-1-2016
845-025-2840	6-29-2016	Adopt	8-1-2016
845-025-2840	6-30-2016	Amend(T)	8-1-2016
845-025-2860	1-1-2016	Adopt(T)	1-1-2016
845-025-2860	6-29-2016	Adopt	8-1-2016
845-025-2880	1-1-2016	Adopt(T)	1-1-2016
845-025-2880	6-29-2016	Adopt	8-1-2016
845-025-2890	1-1-2016	Adopt(T)	1-1-2016
845-025-2890	6-29-2016	Adopt	8-1-2016
845-025-2900	6-30-2016	Adopt(T)	8-1-2016
845-025-2910	6-30-2016	Adopt(T)	8-1-2016
845-025-3200	1-1-2016	Adopt(T)	1-1-2016
845-025-3200	6-29-2016	Adopt	8-1-2016
845-025-3210	1-1-2016	Adopt(T)	1-1-2016
845-025-3210	6-29-2016	Adopt	8-1-2016
845-025-3215	6-29-2016	Adopt	8-1-2016
845-025-3215	6-30-2016	Amend(T)	8-1-2016
845-025-3220	1-1-2016	Adopt(T)	1-1-2016
845-025-3220	6-29-2016	Adopt	8-1-2016
845-025-3230	1-1-2016	Adopt(T)	1-1-2016
845-025-3230	6-29-2016	Adopt	8-1-2016
845-025-3240	1-1-2016	Adopt(T)	1-1-2016
845-025-3240	6-29-2016	Adopt	8-1-2016
845-025-3250	1-1-2016	Adopt(T)	1-1-2016
845-025-3250	6-29-2016	Adopt	8-1-2016
845-025-3260	1-1-2016	Adopt(T)	1-1-2016
845-025-3260	6-29-2016	Adopt	8-1-2016
845-025-3280	1-1-2016	Adopt(T)	1-1-2016
845-025-3280	6-29-2016	Adopt	8-1-2016
845-025-3290	1-1-2016	Adopt(T)	1-1-2016
845-025-3290	6-29-2016	Adopt	8-1-2016
845-025-3300	6-30-2016	Adopt(T)	8-1-2016
845-025-3310	6-30-2016	Adopt(T)	8-1-2016
845-025-3500	1-1-2016	Adopt(T)	1-1-2016
845-025-3500	6-29-2016	Adopt	8-1-2016
845-025-3500	6-30-2016	Amend(T)	8-1-2016
845-025-3510	6-30-2016	Adopt(T)	8-1-2016
845-025-3600	6-30-2016	Adopt(T)	8-1-2016
845-025-5000	1-1-2016	Adopt(T)	1-1-2016
845-025-5000	6-29-2016	Adopt	8-1-2016
845-025-5000	6-30-2016	Amend(T)	8-1-2016
845-025-5030	1-1-2016	Adopt(T)	1-1-2016
845-025-5030	6-29-2016	Adopt	8-1-2016
845-025-5045	1-1-2016	Adopt(T)	1-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
845-025-5045	6-29-2016	Adopt	8-1-2016
845-025-5060	1-1-2016	Adopt(T)	1-1-2016
845-025-5060	6-29-2016	Adopt	8-1-2016
845-025-5075	1-1-2016	Adopt(T)	1-1-2016
845-025-5075	6-29-2016	Adopt	8-1-2016
845-025-5300	1-1-2016	Adopt(T)	1-1-2016
845-025-5300	6-29-2016	Adopt	8-1-2016
845-025-5300	6-30-2016	Amend(T)	8-1-2016
845-025-5350	1-1-2016	Adopt(T)	1-1-2016
845-025-5350	6-29-2016	Adopt	8-1-2016
845-025-5350	6-30-2016	Amend(T)	8-1-2016
845-025-5500	1-1-2016	Adopt(T)	1-1-2016
845-025-5500	6-29-2016	Adopt	8-1-2016
845-025-5500	6-30-2016	Amend(T)	8-1-2016
845-025-5520	1-1-2016	Adopt(T)	1-1-2016
845-025-5520	6-29-2016	Adopt	8-1-2016
845-025-5540	1-1-2016	Adopt(T)	1-1-2016
845-025-5540	6-29-2016	Adopt	8-1-2016
845-025-5540	6-30-2016	Amend(T)	8-1-2016
845-025-5560	1-1-2016	Adopt(T)	1-1-2016
845-025-5560	6-29-2016	Adopt	8-1-2016
845-025-5580	1-1-2016	Adopt(T)	1-1-2016
845-025-5580	6-29-2016	Adopt	8-1-2016
845-025-5590	1-1-2016	Adopt(T)	1-1-2016
845-025-5590	6-29-2016	Adopt	8-1-2016
845-025-5700	1-1-2016	Adopt(T)	1-1-2016
845-025-5700	6-29-2016	Adopt	8-1-2016
845-025-5720	1-1-2016	Adopt(T)	1-1-2016
845-025-5720	6-29-2016	Adopt	8-1-2016
845-025-5730	6-29-2016	Adopt	8-1-2016
845-025-5740	1-1-2016	Adopt(T)	1-1-2016
845-025-5740	6-29-2016	Adopt	8-1-2016
845-025-5760	1-1-2016	Adopt(T)	1-1-2016
845-025-5760	6-29-2016	Adopt	8-1-2016
845-025-5790	6-29-2016	Adopt	8-1-2016
845-025-7000	1-1-2016	Adopt(T)	1-1-2016
845-025-7000	6-29-2016	Adopt	8-1-2016
845-025-7020	1-1-2016	Adopt(T)	1-1-2016
845-025-7020	2-23-2016	Amend(T)	4-1-2016
845-025-7020	6-29-2016	Adopt	8-1-2016
845-025-7030	6-29-2016	Adopt	8-1-2016
845-025-7040	1-1-2016	Adopt(T)	1-1-2016
845-025-7040	6-29-2016	Adopt	8-1-2016
845-025-7060	1-1-2016	Adopt(T)	1-1-2016
845-025-7060	6-29-2016	Adopt	8-1-2016
845-025-7500	1-1-2016	Adopt(T)	1-1-2016
845-025-7500	6-29-2016	Adopt	8-1-2016
845-025-7520	1-1-2016	Adopt(T)	1-1-2016
845-025-7520	6-29-2016	Adopt	8-1-2016
845-025-7540	1-1-2016	Adopt(T)	1-1-2016
845-025-7540	6-29-2016	Adopt	8-1-2016
845-025-7560	1-1-2016	Adopt(T)	1-1-2016
845-025-7560	6-29-2016	Adopt	8-1-2016
845-025-7570	6-29-2016	Adopt	8-1-2016
845-025-7580	1-1-2016	Adopt(T)	1-1-2016
845-025-7580	6-29-2016	Adopt	8-1-2016
845-025-7590	1-1-2016	Adopt(T)	1-1-2016
845-025-7590	6-29-2016	Adopt	8-1-2016
845-025-7700	1-1-2016	Adopt(T)	1-1-2016
845-025-7700	6-29-2016	Adopt	8-1-2016
845-025-7750	1-1-2016	Adopt(T)	1-1-2016
845-025-7750	6-29-2016	Adopt	8-1-2016
845-025-8000	1-1-2016	Adopt(T)	1-1-2016
845-025-8000	6-29-2016	Adopt	8-1-2016
845-025-8020	1-1-2016	Adopt(T)	1-1-2016
845-025-8020	6-29-2016	Adopt	8-1-2016
845-025-8040	1-1-2016	Adopt(T)	1-1-2016
845-025-8040	6-29-2016	Adopt	8-1-2016
845-025-8060	1-1-2016	Adopt(T)	1-1-2016
845-025-8060	6-29-2016	Adopt	8-1-2016
845-025-8080	1-1-2016	Adopt(T)	1-1-2016
845-025-8080	6-29-2016	Adopt	8-1-2016
845-025-8500	1-1-2016	Adopt(T)	1-1-2016
845-025-8500	6-29-2016	Adopt	8-1-2016
845-025-8520	1-1-2016	Adopt(T)	1-1-2016
845-025-8520	6-29-2016	Adopt	8-1-2016
845-025-8540	1-1-2016	Adopt(T)	1-1-2016
845-025-8540	6-29-2016	Adopt	8-1-2016
845-025-8560	1-1-2016	Adopt(T)	1-1-2016
845-025-8560	6-29-2016	Adopt	8-1-2016
845-025-8570	6-29-2016	Adopt	8-1-2016
845-025-8580	1-1-2016	Adopt(T)	1-1-2016
845-025-8580	6-29-2016	Adopt	8-1-2016
845-025-8590	1-1-2016	Adopt(T)	1-1-2016
845-025-8590	6-29-2016	Adopt	8-1-2016
845-025-8700	6-29-2016	Adopt	8-1-2016
847-001-0015	1-8-2016	Amend	2-1-2016
847-005-0005	1-8-2016	Amend	2-1-2016
847-008-0020	1-8-2016	Amend	2-1-2016
847-008-0022	1-8-2016	Amend	2-1-2016
847-008-0023	1-8-2016	Amend	2-1-2016
847-008-0025	1-8-2016	Amend	2-1-2016
847-008-0030	1-8-2016	Amend	2-1-2016
847-008-0035	1-8-2016	Amend	2-1-2016
847-008-0037	1-8-2016	Amend	2-1-2016
847-008-0050	1-8-2016	Amend	2-1-2016
847-008-0055	1-8-2016	Amend	2-1-2016
847-008-0056	1-8-2016	Repeal	2-1-2016
847-008-0070	4-8-2016	Amend	5-1-2016
847-010-0073	1-8-2016	Amend	2-1-2016
847-015-0005	7-8-2016	Amend	8-1-2016
847-015-0010	7-8-2016	Amend	8-1-2016
847-015-0030	7-8-2016	Amend	8-1-2016
847-017-0003	4-8-2016	Amend	5-1-2016
847-017-0015	4-8-2016	Amend	5-1-2016
847-017-0020	4-8-2016	Amend	5-1-2016
847-020-0135	1-1-2016	Adopt	1-1-2016
847-023-0005	4-8-2016	Amend	5-1-2016
847-050-0010	9-1-2016	Amend	8-1-2016
847-050-0025	1-8-2016	Amend	2-1-2016
847-050-0025(T)	1-8-2016	Repeal	2-1-2016
847-050-0027	9-1-2016	Amend	8-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
847-050-0036	9-1-2016	Adopt	8-1-2016
847-050-0037	9-1-2016	Amend	8-1-2016
847-050-0040	9-1-2016	Amend	8-1-2016
847-050-0043	1-8-2016	Amend	2-1-2016
847-050-0063	1-8-2016	Repeal	2-1-2016
847-050-0065	1-8-2016	Repeal	2-1-2016
847-070-0045	1-8-2016	Amend	2-1-2016
847-080-0010	4-8-2016	Amend	5-1-2016
847-080-0018	4-8-2016	Amend	5-1-2016
847-080-0021	4-8-2016	Amend	5-1-2016
847-080-0022	4-8-2016	Amend	5-1-2016
847-080-0035	4-8-2016	Amend	5-1-2016
850-005-0190	12-30-2015	Amend	2-1-2016
850-060-0226	12-30-2015	Amend	2-1-2016
851-002-0010	8-1-2016	Amend	8-1-2016
851-031-0005	1-1-2016	Amend	1-1-2016
851-031-0086	1-1-2016	Amend	1-1-2016
851-050-0138	11-24-2015	Amend(T)	1-1-2016
851-050-0138	4-1-2016	Amend	4-1-2016
851-056-0000	11-30-2015	Amend(T)	1-1-2016
851-056-0000	4-1-2016	Amend	4-1-2016
851-056-0020	11-30-2015	Amend(T)	1-1-2016
851-056-0020	4-1-2016	Amend	4-1-2016
851-070-0000	8-1-2016	Amend	8-1-2016
851-070-0005	8-1-2016	Amend	8-1-2016
851-070-0010	8-1-2016	Amend	8-1-2016
851-070-0020	8-1-2016	Amend	8-1-2016
851-070-0025	8-1-2016	Adopt	8-1-2016
851-070-0030	8-1-2016	Amend	8-1-2016
851-070-0040	8-1-2016	Amend	8-1-2016
851-070-0045	8-1-2016	Adopt	8-1-2016
851-070-0050	8-1-2016	Amend	8-1-2016
851-070-0060	8-1-2016	Amend	8-1-2016
851-070-0070	8-1-2016	Amend	8-1-2016
851-070-0075	8-1-2016	Adopt	8-1-2016
851-070-0080	8-1-2016	Amend	8-1-2016
851-070-0090	8-1-2016	Amend	8-1-2016
851-070-0100	8-1-2016	Amend	8-1-2016
852-010-0015	4-1-2016	Amend	4-1-2016
852-010-0080	4-1-2016	Amend	4-1-2016
852-010-0080	4-8-2016	Amend	5-1-2016
852-050-0006	4-1-2016	Amend	4-1-2016
852-050-0014	4-1-2016	Amend	4-1-2016
852-050-0018	4-1-2016	Amend	4-1-2016
852-050-0025	4-1-2016	Amend	4-1-2016
852-050-0025	4-8-2016	Amend	5-1-2016
852-070-0010	4-1-2016	Amend	4-1-2016
852-070-0020	4-1-2016	Amend	4-1-2016
852-070-0035	4-1-2016	Amend	4-1-2016
852-070-0037	4-1-2016	Adopt	4-1-2016
852-070-0047	4-1-2016	Adopt	4-1-2016
855-006-0005	12-23-2015	Amend	2-1-2016
855-006-0005	7-1-2016	Amend	8-1-2016
855-006-0020	7-1-2016	Adopt	8-1-2016
855-019-0110	12-23-2015	Amend	2-1-2016
855-019-0200	12-23-2015	Amend	2-1-2016
855-019-0264	12-23-2015	Adopt	2-1-2016
855-019-0270	12-23-2015	Amend	2-1-2016
855-019-0280	12-23-2015	Amend	2-1-2016
855-019-0400	5-1-2016	Adopt	6-1-2016
855-019-0400(T)	5-1-2016	Repeal	6-1-2016
855-019-0405	5-1-2016	Adopt	6-1-2016
855-019-0405(T)	5-1-2016	Repeal	6-1-2016
855-019-0410	5-1-2016	Adopt	6-1-2016
855-019-0410(T)	5-1-2016	Repeal	6-1-2016
855-019-0415	5-1-2016	Adopt	6-1-2016
855-019-0415(T)	5-1-2016	Repeal	6-1-2016
855-019-0420	5-1-2016	Adopt	6-1-2016
855-019-0420(T)	5-1-2016	Repeal	6-1-2016
855-019-0425	5-1-2016	Adopt	6-1-2016
855-019-0425(T)	5-1-2016	Repeal	6-1-2016
855-019-0430	5-1-2016	Adopt	6-1-2016
855-019-0430(T)	5-1-2016	Repeal	6-1-2016
855-019-0435	5-1-2016	Adopt	6-1-2016
855-019-0435(T)	5-1-2016	Repeal	6-1-2016
855-025-0001	7-1-2016	Amend	8-1-2016
855-025-0005	7-1-2016	Amend	8-1-2016
855-025-0010	7-1-2016	Amend	8-1-2016
855-025-0012	7-1-2016	Amend	8-1-2016
855-025-0015	12-23-2015	Amend	2-1-2016
855-025-0015	7-1-2016	Amend	8-1-2016
855-025-0015(T)	12-23-2015	Repeal	2-1-2016
855-025-0060	7-1-2016	Amend	8-1-2016
855-041-1120	7-1-2016	Amend	2-1-2016
855-041-4200	7-1-2016	Amend	8-1-2016
855-043-0110	7-1-2016	Repeal	8-1-2016
855-043-0130	12-23-2015	Amend	2-1-2016
855-043-0130	7-1-2016	Repeal	8-1-2016
855-043-0130(T)	12-23-2015	Repeal	2-1-2016
855-043-0300	7-1-2016	Repeal	8-1-2016
855-043-0310	7-1-2016	Repeal	8-1-2016
855-043-0700	7-1-2016	Adopt	8-1-2016
855-043-0705	7-1-2016	Adopt	8-1-2016
855-043-0710	7-1-2016	Adopt	8-1-2016
855-043-0715	7-1-2016	Adopt	8-1-2016
855-043-0720	7-1-2016	Adopt	8-1-2016
855-043-0725	7-1-2016	Adopt	8-1-2016
855-043-0730	7-1-2016	Adopt	8-1-2016
855-043-0735	7-1-2016	Adopt	8-1-2016
855-043-0740	7-1-2016	Adopt	8-1-2016
855-043-0745	7-1-2016	Adopt	8-1-2016
855-043-0750	7-1-2016	Adopt	8-1-2016
855-062-0040	12-23-2015	Amend	2-1-2016
855-062-0040(T)	12-23-2015	Repeal	2-1-2016
855-090-0005	12-23-2015	Repeal	2-1-2016
855-110-0003	7-1-2016	Amend	8-1-2016
855-110-0005	7-1-2016	Amend	8-1-2016
855-110-0007	7-1-2016	Amend	8-1-2016
855-110-0010	7-1-2016	Amend	8-1-2016
856-010-0010	3-31-2016	Amend	5-1-2016
856-010-0012	1-25-2016	Amend	3-1-2016
856-010-0012	2-10-2016	Amend	3-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
856-010-0026	3-31-2016	Amend	5-1-2016
856-030-0040	5-25-2016	Amend(T)	7-1-2016
858-010-0007	2-1-2016	Amend	3-1-2016
858-010-0020	2-1-2016	Amend	3-1-2016
858-010-0020	5-23-2016	Amend	7-1-2016
858-010-0036	2-2-2016	Amend	3-1-2016
858-010-0041	6-15-2016	Amend	7-1-2016
858-020-0075	5-23-2016	Amend	7-1-2016
858-040-0035	2-1-2016	Amend	3-1-2016
858-040-0055	2-1-2016	Amend	3-1-2016
858-040-0065	2-1-2016	Amend	3-1-2016
859-010-0005	12-3-2015	Amend(T)	1-1-2016
859-020-0005	3-17-2016	Amend	5-1-2016
859-020-0010	3-17-2016	Amend	5-1-2016
859-020-0015	3-17-2016	Amend	5-1-2016
859-030-0005	3-17-2016	Amend	5-1-2016
859-030-0010	3-17-2016	Amend	5-1-2016
859-040-0005	3-17-2016	Amend	5-1-2016
859-040-0010	3-17-2016	Amend	5-1-2016
859-040-0015	3-17-2016	Amend	5-1-2016
859-040-0020	3-17-2016	Amend	5-1-2016
859-040-0025	3-17-2016	Amend	5-1-2016
859-045-0005	3-17-2016	Adopt	5-1-2016
859-045-0010	3-17-2016	Adopt	5-1-2016
859-050-0001	3-17-2016	Adopt	5-1-2016
859-050-0005	3-17-2016	Amend	5-1-2016
859-050-0010	3-17-2016	Amend	5-1-2016
859-050-0015	3-17-2016	Amend	5-1-2016
859-050-0020	3-17-2016	Amend	5-1-2016
859-050-0025	3-17-2016	Amend	5-1-2016
859-050-0030	3-17-2016	Amend	5-1-2016
859-050-0035	3-17-2016	Amend	5-1-2016
859-050-0040	3-17-2016	Amend	5-1-2016
859-050-0045	3-17-2016	Amend	5-1-2016
859-050-0050	3-17-2016	Amend	5-1-2016
859-050-0055	3-17-2016	Amend	5-1-2016
859-050-0060	3-17-2016	Amend	5-1-2016
859-050-0065	3-17-2016	Amend	5-1-2016
859-050-0070	3-17-2016	Amend	5-1-2016
859-050-0075	3-17-2016	Amend	5-1-2016
859-050-0080	3-17-2016	Amend	5-1-2016
859-050-0083	3-17-2016	Adopt	5-1-2016
859-050-0085	3-17-2016	Amend	5-1-2016
859-050-0090	3-17-2016	Amend	5-1-2016
859-050-0095	3-17-2016	Amend	5-1-2016
859-050-0100	3-17-2016	Amend	5-1-2016
859-050-0105	3-17-2016	Amend	5-1-2016
859-200-0070	3-17-2016	Amend	5-1-2016
859-400-0001	3-17-2016	Adopt	5-1-2016
859-400-0005	3-17-2016	Adopt	5-1-2016
859-400-0010	3-17-2016	Adopt	5-1-2016
859-400-0015	3-17-2016	Adopt	5-1-2016
859-400-0020	3-17-2016	Adopt	5-1-2016
859-400-0025	3-17-2016	Adopt	5-1-2016
859-400-0030	3-17-2016	Adopt	5-1-2016
859-400-0035	3-17-2016	Adopt	5-1-2016
859-400-0040	3-17-2016	Adopt	5-1-2016
859-400-0045	3-17-2016	Adopt	5-1-2016
860-024-0020	5-17-2016	Amend	7-1-2016
860-024-0021	5-17-2016	Amend	7-1-2016
860-038-0300	3-10-2016	Amend	4-1-2016
860-200-0005	5-3-2016	Adopt	6-1-2016
860-200-0005(T)	5-3-2016	Repeal	6-1-2016
860-200-0050	5-3-2016	Adopt	6-1-2016
860-200-0050(T)	5-3-2016	Repeal	6-1-2016
860-200-0100	5-3-2016	Adopt	6-1-2016
860-200-0100(T)	5-3-2016	Repeal	6-1-2016
860-200-0150	5-3-2016	Adopt	6-1-2016
860-200-0150(T)	5-3-2016	Repeal	6-1-2016
863-060-0011	4-25-2016	Adopt	6-1-2016
863-060-0011	5-13-2016	Adopt	6-1-2016
877-001-0020	1-1-2016	Amend	2-1-2016
877-015-0108	3-14-2016	Amend(T)	4-1-2016
877-020-0005	12-15-2015	Amend	1-1-2016
877-020-0009	3-14-2016	Amend(T)	4-1-2016
877-020-0021	12-15-2015	Adopt	1-1-2016
877-030-0110	1-1-2016	Adopt	2-1-2016
918-020-0090	1-1-2016	Amend	1-1-2016
918-020-0090(T)	1-1-2016	Repeal	1-1-2016
918-098-1010	1-26-2016	Amend(T)	3-1-2016
918-098-1010	4-1-2016	Amend	5-1-2016
918-098-1010	7-1-2016	Amend	8-1-2016
918-098-1010(T)	4-1-2016	Repeal	5-1-2016
918-098-1012	4-1-2016	Amend	5-1-2016
918-098-1012	7-1-2016	Amend	8-1-2016
918-098-1015	4-1-2016	Amend	5-1-2016
918-098-1015	7-1-2016	Amend	8-1-2016
918-098-1025	1-26-2016	Amend(T)	3-1-2016
918-098-1025	4-1-2016	Amend	5-1-2016
918-098-1025	7-1-2016	Amend	8-1-2016
918-098-1025(T)	4-1-2016	Repeal	5-1-2016
918-098-1028	7-1-2016	Amend	8-1-2016
918-098-1100	7-1-2016	Adopt	8-1-2016
918-098-1210	4-1-2016	Amend	5-1-2016
918-098-1215	4-1-2016	Amend	5-1-2016
918-098-1305	4-1-2016	Amend	5-1-2016
918-098-1320	4-1-2016	Amend	5-1-2016
918-098-1470	1-26-2016	Amend(T)	3-1-2016
918-098-1470	4-1-2016	Amend	5-1-2016
918-098-1470(T)	4-1-2016	Repeal	5-1-2016
918-098-1475	7-1-2016	Adopt	8-1-2016
918-098-1480	1-26-2016	Amend(T)	3-1-2016
918-098-1480	4-1-2016	Amend	5-1-2016
918-098-1480(T)	4-1-2016	Repeal	5-1-2016
918-098-1900	1-26-2016	Amend(T)	3-1-2016
918-098-1900	4-1-2016	Amend	5-1-2016
918-098-1900(T)	4-1-2016	Repeal	5-1-2016
918-271-0040	1-1-2016	Amend	1-1-2016
918-271-0105	4-1-2016	Adopt	5-1-2016
918-309-0000	4-1-2016	Amend	5-1-2016
918-309-0030	4-1-2016	Amend	5-1-2016
918-309-0040	4-1-2016	Amend	5-1-2016

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
918-309-0060	4-1-2016	Amend	5-1-2016
918-309-0070	4-1-2016	Amend	5-1-2016
918-309-0075	4-1-2016	Adopt	5-1-2016
918-440-0012	7-1-2016	Amend	8-1-2016
918-460-0015	2-1-2016	Amend	3-1-2016
918-460-0500	3-3-2016	Amend(T)	4-1-2016
918-480-0010	2-1-2016	Amend	3-1-2016
918-480-0100	6-28-2016	Suspend	8-1-2016
918-480-0110	6-28-2016	Suspend	8-1-2016
918-480-0120	6-28-2016	Suspend	8-1-2016
918-480-0125	6-28-2016	Adopt(T)	8-1-2016
918-695-0410	4-1-2016	Amend	5-1-2016
945-030-0020	3-25-2016	Amend(T)	5-1-2016
945-030-0030	4-12-2016	Amend	5-1-2016
945-030-0035	4-12-2016	Repeal	5-1-2016
951-006-0000	6-21-2016	Amend	8-1-2016
951-006-0001	6-21-2016	Amend	8-1-2016
951-006-0005	6-21-2016	Amend	8-1-2016
951-006-0010	6-21-2016	Amend	8-1-2016
951-006-0020	6-21-2016	Amend	8-1-2016
976-002-0020	7-1-2016	Amend	8-1-2016

OAR Number	Effective	Action	Bulletin